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# Health Care Appropriations Subcommittee

February 8, 2016  
2:00 PM – 5:00 PM  
Webster Hall (212 Knott)

## Meeting Packet



# **The Florida House of Representatives**

## **Appropriations Committee**

### **Health Care Appropriations Subcommittee**

**Steve Crisafulli**  
Speaker

**Matt Hudson**  
Chair

February 8, 2016

AGENDA  
2:00 PM – 5:00 PM  
Webster Hall

- I. Call to Order/Roll Call
- II. CS/HB 307--Experimental Treatments for Terminal Conditions by Gaetz
- III. CS/HB 599--Child Welfare by Combee
- IV. HB 1175--Transparency in Health Care by Sprowls
- V. HB 7087—Telehealth by Sprowls
- VI. HB 7097--Mental Health and Substance Abuse by Harrell
- VII. Closing/Adjourn



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 307 Experimental Treatments for Terminal Conditions  
**SPONSOR(S):** Criminal Justice Subcommittee; Gaetz; Edwards and others  
**TIED BILLS:** None **IDEN./SIM. BILLS:** SB 460

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Criminal Justice Subcommittee	9 Y, 4 N, As CS	White	White
2) Health Care Appropriations Subcommittee		Garner 	Pridgeon 
3) Health & Human Services Committee			

### SUMMARY ANALYSIS

Under the Florida Comprehensive Drug Abuse Prevention and Control Act, cannabis is a Schedule I controlled substance and, as such, criminal penalties ranging from first degree misdemeanors to second degree felonies apply to the unlawful possession, use, sale, purchase, manufacture, delivery, transport, or trafficking of cannabis. Currently, the only statutorily-allowed use of cannabis in this state is set forth in the Compassionate Medical Cannabis Act of 2014 (CMCA), which authorizes dispensing organizations approved by the Department of Health (DOH) to manufacture, possess, sell, and dispense low-THC cannabis for medical use by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms.

In 2015, the Legislature adopted the Right to Try Act (RTTA). The RTTA authorizes an eligible patient with a "terminal condition," meaning that the patient will die within one year if the condition runs its normal course, to receive an "investigational drug, biological product, or device," meaning a drug, product, or device that has successfully completed phase 1 of a clinical trial, but that has not been approved for general use by the United States Food and Drug Administration.

The bill amends the definition of "investigational drug, biological product, or device" set forth in the RTTA to include cannabis that is manufactured and sold by one of 20 dispensing organizations that must be approved by the DOH under the bill. The bill further specifies that, notwithstanding the state's laws criminalizing the non-medical use of cannabis, eligible patients under the RTTA or their legal representatives may purchase and possess cannabis for the patient's medical use and dispensing organizations may manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of cannabis.

The bill will have a significant negative fiscal impact on the DOH and requires 12 full time equivalent positions and budget authority of \$1,299,367 recurring and \$46,584 nonrecurring for the processing of dispensing organization applications costs. The bill does not appear to have a fiscal impact on state or local governments.

The bill takes effect July 1, 2016.

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### Florida's Cannabis Laws

###### *Non-Medical Use of Cannabis*

Florida's drug control laws are set forth in ch. 893, F.S., entitled the Florida Comprehensive Drug Abuse Prevention and Control Act (Drug Control Act).<sup>1</sup> The Drug Control Act classifies controlled substances into five categories, ranging from Schedule I to Schedule V.<sup>2</sup> Cannabis is currently a Schedule I controlled substance,<sup>3</sup> which means it has a high potential for abuse, it has no currently accepted medical use in treatment in the United States, and its use under medical supervision does not meet accepted safety standards.<sup>4</sup> Cannabis is defined as:

All parts of any plant of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin. The term does not include "low-THC cannabis," as defined in s. 381.986, if manufactured, possessed, sold, purchased, delivered, distributed, or dispensed, in conformance with s. 381.986.<sup>5</sup>

The Drug Control Act contains a variety of provisions criminalizing behavior related to cannabis:

- Section 893.13, F.S., makes it a crime to sell, manufacture, deliver, purchase, or possess cannabis. The penalties for these offenses range from first degree misdemeanors to second degree felonies.<sup>6</sup>
- Section 893.135(1)(a), F.S., makes it a first degree felony<sup>7</sup> to traffic in cannabis, i.e., to possess, sell, purchase, manufacture, deliver, or import more than 25 pounds of cannabis or 300 or more cannabis plants. Depending on the amount of cannabis or cannabis plants trafficked, mandatory minimum sentences of three to 15 years and fines of \$25,000 to \$200,000 apply to a conviction.<sup>8</sup>
- Section 893.147, F.S., makes it a crime to possess, use, deliver, manufacture, transport, or sell drug paraphernalia.<sup>9</sup> The penalties for these offenses range from first degree misdemeanors to second degree felonies.<sup>10</sup>

###### *Florida's Medical Necessity Defense*

Florida courts have held that persons charged with offenses based on the possession, use, or manufacture of marijuana may use the medical necessity defense, which requires a defendant to prove that:

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<sup>1</sup> s. 893.01, F.S.

<sup>2</sup> s. 893.03, F.S.

<sup>3</sup> s. 893.03(1)(c)7., F.S.

<sup>4</sup> s. 893.03(1), F.S.

<sup>5</sup> s. 893.02(3), F.S.

<sup>6</sup> A first degree misdemeanor is punishable by up to one year in county jail and a \$1,000 fine; a third degree felony is punishable by up to five years imprisonment and a \$5,000 fine; and a second degree felony is punishable by up to 15 years imprisonment and a \$10,000 fine. ss. 775.082 and 775.083, F.S.

<sup>7</sup> A first degree felony is punishable by up to 30 years imprisonment and a \$10,000 fine. ss. 775.082 and 775.083, F.S.

<sup>8</sup> s. 893.13(1)(a), F.S.

<sup>9</sup> Drug paraphernalia is defined in s. 893.145, F.S., as:

All equipment, products, and materials of any kind which are used, intended for use, or designed for use in the planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, transporting, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of ch. 893, F.S., or s. 877.111, F.S.

<sup>10</sup> s. 893.147, F.S.

- He or she did not intentionally bring about the circumstance which precipitated the unlawful act;
- He or she could not accomplish the same objective using a less offensive alternative; and
- The evil sought to be avoided was more heinous than the unlawful act.<sup>11</sup>

In *Jenks v. State*,<sup>12</sup> the defendants, a married couple, suffered from uncontrollable nausea due to AIDS treatment and had testimony from their physician that they could find no effective alternative treatment. The defendants tried cannabis, and after finding that it successfully treated their symptoms, decided to grow two cannabis plants.<sup>13</sup> They were subsequently charged with manufacturing and possession of drug paraphernalia. Under these facts, the First District Court of Appeal found that “section 893.03 does not preclude the defense of medical necessity” and that the Jenks met the criteria for the medical necessity defense.<sup>14</sup> The court ordered the Jenks to be acquitted.<sup>15</sup>

Seven years after the *Jenks* decision, the First District Court of Appeal again recognized the medical necessity defense in *Sowell v. State*.<sup>16</sup> More recently, the State Attorney’s Office in the Twelfth Judicial Circuit cited the medical necessity defense as the rationale for not prosecuting a person arrested for cultivating a small amount of cannabis in his home for his wife’s medical use.<sup>17</sup>

### *Compassionate Medical Cannabis Act of 2014*

The Compassionate Medical Cannabis Act of 2014<sup>18</sup> (CMCA) legalized a low tetrahydrocannabinol (THC) and high cannabidiol (CBD) form of cannabis (low-THC cannabis)<sup>19</sup> for the medical use<sup>20</sup> by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms.

The CMCA provides that a Florida licensed allopathic or osteopathic physician who has completed certain training<sup>21</sup> and has examined and is treating such a patient may order low-THC cannabis for that patient to treat the disease, disorder, or condition or to alleviate its symptoms, if no other satisfactory alternative treatment options exist for the patient. To meet the requirements of the CMCA, each of the following conditions must be satisfied:

- The patient must be a permanent resident of Florida.

<sup>11</sup> *Jenks v. State*, 582 So.2d 676, 679 (Fla. 1st DCA 1991), *rev. denied*, 589 So.2d 292 (Fla.1991).

<sup>12</sup> 582 So.2d 676 (Fla. 1st DCA 1991).

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> 739 So.2d 333 (Fla. 1st DCA 1998).

<sup>17</sup> *Interdepartmental Memorandum*, State Attorney’s Office for the Twelfth Judicial Circuit of Florida, SAO Case # 13CF007016AM, April 2, 2013 (on file with Judiciary Committee staff).

<sup>18</sup> See ch. 2014-157, L.O.F., and s. 381.986, F.S.

<sup>19</sup> The act defined “low-THC cannabis,” as the dried flowers of the plant *Cannabis* which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight, or the seeds, resin, or any compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin. See s. 381.986(1)(b), F.S. Eleven states allow limited access to marijuana products (low-THC and/or high CBD-cannabidiol): Alabama, Florida, Iowa, Kentucky, Mississippi, Missouri, North Carolina, South Carolina, Tennessee, Utah, and Wisconsin. Twenty-three states, the District of Columbia, and Guam have laws that permit the use of marijuana for medicinal purposes. See *infra* note 28. See <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx> (Tables 1 and 2), (last visited on March 27, 2015).

<sup>20</sup> Section 381.986(1)(c), F.S., defines “medical use” as “administration of the ordered amount of low-THC cannabis. The term does not include the possession, use, or administration by smoking. The term also does not include the transfer of low-THC cannabis to a person other than the qualified patient for whom it was ordered or the qualified patient’s legal representative on behalf of the qualified patient.” Section 381.986(1)(e), F.S., defines “smoking” as “burning or igniting a substance and inhaling the smoke. Smoking does not include the use of a vaporizer.”

<sup>21</sup> Section 381.986(4), F.S., requires such physicians to successfully complete an 8-hour course and examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which encompasses the clinical indications for the appropriate use of low-THC cannabis, appropriate delivery mechanisms, contraindications for such use, and the state and federal laws governing its ordering, dispensing, and processing

- The physician must determine that the risks of ordering low-THC cannabis are reasonable in light of the potential benefit for that patient.<sup>22</sup>
- The physician must register as the orderer of low-THC cannabis for the patient on the compassionate use registry (registry) maintained by the Department of Health (DOH) and must update the registry to reflect the contents of the order.
- The physician must maintain a patient treatment plan and must submit the plan quarterly to the University of Florida College Of Pharmacy.
- The physician must obtain the voluntary informed consent of the patient or the patient's legal guardian to treatment with low-THC cannabis.<sup>23</sup>

Under the CMCA, DOH was required to approve five dispensing organizations by January 1, 2015, with one dispensing organization in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida, and southwest Florida.<sup>24</sup> To be approved as a dispensing organization, an applicant must establish that it:

- Possesses a certificate of registration issued by the Department of Agriculture and Consumer Services for the cultivation of more than 400,000 plants;
- Is operated by a nurseryman;
- Has been operating as a registered nursery in this state for at least 30 continuous years;
- Has the technical and technological ability to cultivate and produce low-THC cannabis;
- Employs a medical director, who must be a physician and have successfully completed a course and examination that encompasses appropriate safety procedures and knowledge of low-THC cannabis; and
- Other specified requirements.<sup>25</sup>

Implementation by DOH of the dispensing organization approval process was delayed due to litigation challenging proposed rules that addressed the initial application requirements for dispensing organizations, revocation of dispensing organization approval, and inspection and cultivation authorization procedures for dispensing organizations. Such litigation was resolved on May 27, 2015, with an order entered by the Division of Administrative Hearings holding that the challenged rules do not constitute an invalid exercise of delegated legislative authority.<sup>26</sup> Thereafter, the rules took effect on June 17, 2015.<sup>27</sup>

The application process to become a dispensing organization closed on July 8, 2015, with 28 applications received by DOH. As of November 13, 2015, DOH is continuing to conduct its review process to select the five approved dispensing organizations as directed by statute.<sup>28</sup>

The CMCA provides that it is a first degree misdemeanor for:

- A physician to order low-THC cannabis for a patient without a reasonable belief that the patient is suffering from a required condition; or
- Any person to fraudulently represent that he or she has a required condition to a physician for the purpose of being ordered low-THC cannabis.<sup>29</sup>

The CMCA specifies that notwithstanding ss. 893.13, 893.135, or 893.147, F.S., or any other law that:

- Qualified patients<sup>30</sup> and their legal representatives may purchase and possess low-THC cannabis up to the amount ordered for the patient's medical use.

<sup>22</sup> If a patient is younger than 18 years of age, a second physician must concur with this determination, and such determination must be documented in the patient's medical record. s. 381.986(2)(b), F.S.

<sup>23</sup> s. 381.986(2), F.S.

<sup>24</sup> s. 381.986(5)(b), F.S.

<sup>25</sup> *Id.*

<sup>26</sup> *Baywood v. Nurseries Co., Inc. v. Department of Health*, Case No. 15-1694RP (Fla. DOAH May 27, 2015).

<sup>27</sup> Rule Chapter 64-4, F.A.C.

<sup>28</sup> Telephone call with staff of the Department of Health (November 13, 2015).

<sup>29</sup> s. 381.986(3), F.S.

- Approved dispensing organizations and their owners, managers, and employees may manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of reasonable quantities, as established by DOH rule, of low-THC cannabis. Such dispensing organizations and their owners, managers, and employees are not subject to licensure or regulation under ch. 465, F.S., relating to pharmacies.<sup>31</sup>

#### *The Compassionate Use Registry*

The CMCA requires DOH to create a secure, electronic, and online registry for the registration of physicians and patients.<sup>32</sup> Physicians must register as the orderer of low-THC cannabis for a named patient on the registry and must update the registry to reflect the contents of the order.<sup>33</sup> The registry must prevent an active registration of a patient by multiple physicians and must be accessible to law enforcement agencies and to a dispensing organization to verify patient authorization for low-THC cannabis and to record the low-THC cannabis dispensed.<sup>34</sup>

#### *Medical Cannabis Laws in Other States*

Currently, 23 states<sup>35</sup> and the District of Columbia have laws that permit the use of cannabis for medicinal purposes. While these laws vary widely, most include the following:

- A list of medical conditions for which a practitioner may order medical cannabis for a patient.
  - While nearly every state has a list of medical conditions, the particular conditions vary from state to state. Most states also include a way to expand the list either by allowing a state agency or board to add medical conditions to the list or by including a “catch-all” phrase. Most states require that the patient receive certification from at least one, but often two, physicians designating that the patient has a qualifying condition.
- Provisions allowing the patient to designate one or more caregivers who can possess the medical cannabis and assist the patient in preparing and using the medical cannabis.
- Provisions specifying the number of caregivers allowed and the qualifications to become a caregiver. Most states allow one or two caregivers, require that they be at least 21, and prohibit the caregiver from being the patient’s physician. Caregivers are generally allowed to purchase or grow cannabis for the patient, be in possession of a specified quantity of cannabis, and aid the patient in using cannabis, but are strictly prohibited from using cannabis themselves.
- A requirement that the patient or caregiver have an ID card, typically issued by a state agency.
- The creation of a registry of people who have been issued an identification card.
- A method for registered patients and caregivers to obtain medical cannabis.
  - There are two general methods by which patients can obtain medical cannabis. They must either self-cultivate the cannabis in their homes, or buy cannabis from specified points of sale or dispensaries. Regulations governing such dispensaries vary widely.
- General restrictions on where medical cannabis may be used.
  - Typically, medical cannabis may not be used in public places, such as parks and on buses, or in areas where there are more stringent restrictions placed on the use of drugs, such as in or around schools or in prisons.

#### *Interaction of State Medical Marijuana Laws with Federal Law*

The Federal Controlled Substances Act<sup>36</sup> lists cannabis as a Schedule 1 drug with no accepted medical uses.<sup>37</sup> Like the Florida’s Drug Control Act, the Federal Controlled Substances Act imposes penalties

<sup>30</sup> Section 381.986(1)(d), F.S., provides that a “qualified patient” is a Florida resident who has been added by a physician licensed under ch. 458, F.S. or ch. 459, F.S., to the compassionate use registry to receive low-THC cannabis from a dispensing organization.

<sup>31</sup> s. 381.986(7), F.S.

<sup>32</sup> s. 381.985(5)(a), F.S.

<sup>33</sup> s. 381.986(2)(c), F.S.

<sup>34</sup> s. 381.985(5)(a), F.S.

<sup>35</sup> These states include: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington. California was the first to establish a medical marijuana program in 1996 and New York was the most recent state to pass medical marijuana legislation which took effect in July 2014. <http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx> (last visited on Nov. 18, 2016).

on those who possess, sell, distribute, etc. cannabis.<sup>38</sup> A first misdemeanor offense for possession of cannabis in any amount can result in a \$1,000 fine and up to year in prison, climbing for subsequent offenses to as much as \$5,000 and three years.<sup>39</sup> Selling and cultivating cannabis are subject to even greater penalties.<sup>40</sup>

Although state medical cannabis laws protect patients from prosecution for the legitimate use of cannabis under the guidelines established in that state, such laws do not protect individuals from prosecution under federal law should the federal government choose to enforce those laws. In recent years, however, the federal government appears to have softened its stance on cannabis.

In August of 2013, the United States Justice Department (USDOJ) issued a publication entitled “Smart on Crime: Reforming the Criminal Justice System for the 21st Century.”<sup>41</sup> This document details the federal government’s changing stance on low-level drug crimes announcing a “change in Department of Justice charging policies so that certain people who have committed low-level, nonviolent drug offenses, who have no ties to large-scale organizations, gangs, or cartels will no longer be charged with offenses that impose draconian mandatory minimum sentences. Under the revised policy, these people would instead receive sentences better suited to their individual conduct rather than excessive prison terms more appropriate for violent criminals or drug kingpins.”<sup>42</sup>

On August 29, 2013, United States Deputy Attorney General James Cole issued a memorandum to federal attorneys that appeared to relax the federal government’s cannabis-related offense enforcement policies.<sup>43</sup> The memo stated that the USDOJ was committed to using its limited investigative and prosecutorial resources to address the most significant threats in the most effective, consistent, and rational ways, and outlined eight areas of enforcement priorities.<sup>44</sup> These enforcement priorities focused on offenses that would result in cannabis being distributed to minors, cannabis sale revenues going to criminal gangs or other similar organizations, and cannabis being grown on public lands.<sup>45</sup> The memo indicated that outside of the listed enforcement priorities, the federal government would not enforce federal cannabis-related laws in states that have legalized the drug and that have a robust regulatory scheme in place.<sup>46</sup>

### **Right to Try Act**

During the 2015 Regular Session, the Legislature enacted the “Right to Try Act” (RTTA), which authorizes a manufacturer to provide an eligible patient with an investigational drug, biological product, or device that has successfully completed phase 1 of a clinical trial, but that has not been approved for general use by the United States Food and Drug Administration (FDA), and that remains under investigation in a clinical trial approved by the FDA.<sup>47</sup> The RTTA allows manufacturers to contract with and dispense investigational drugs directly to patients without licensure or regulation under chapter 465, F.S., by the Board of Pharmacy.<sup>48</sup>

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<sup>36</sup> 21 U.S.C. ss. 801-971.

<sup>37</sup> 21 U.S.C. s. 812.

<sup>38</sup> 21 U.S.C. ss. 841-65.

<sup>39</sup> 21 U.S.C. s. 844.

<sup>40</sup> 21 U.S.C. ss. 841-65.

<sup>41</sup> USDOJ, *Smart on Crime: Reforming the Criminal Justice System for the 21st Century*, <http://www.justice.gov/ag/smart-on-crime.pdf>. (last visited on Nov. 15, 2015).

<sup>42</sup> *Id.*

<sup>43</sup> See USDOJ memo on “Guidance Regarding Marijuana Enforcement,” August 29, 2014, <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf> (last visited on Nov. 15, 2015).

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> s. 499.0295(1)-(3), F.S.

<sup>48</sup> s. 499.0295(3) and (7), F.S.

To be eligible to access such drugs, products, or devices, a patient must have a “terminal condition,” which is defined as “a progressive disease or medical or surgical condition that causes significant functional impairment, is not considered by a treating physician to be reversible even with the administration of available treatment options currently approved by the United States Food and Drug Administration, and, without the administration of life-sustaining procedures, will result in death within one year after diagnosis if the condition runs its normal course.”<sup>49</sup> The eligible patient’s treating physician must attest to the terminal condition, such condition must be confirmed by a second evaluation by a board-certified physician in an appropriate specialty, and the patient must have considered all other approved treatments.<sup>50</sup>

The RTTA also requires the patient, a parent of a minor patient, a court-appointed guardian for the patient, or a health care surrogate designated by the patient to provide written informed consent prior to accessing an investigational drug, biological product, or device. The written informed consent must include:

- An explanation of the currently approved products and treatments for the patient’s terminal condition.
- An attestation that the patient agrees with his or her physician in believing that all currently approved products and treatments are unlikely to prolong the patient’s life.
- Identification of the specific name of the investigational drug, biological product, or device.
- A realistic description of the most likely outcome, detailing the possibility of unanticipated or worse symptoms.
- A statement that death could be hastened by use of the investigational drug, biologic product, or device.
- A statement that the patient’s health plan or third-party administrator and physician are not obligated to pay for treatment consequent to the use of the investigational drug, biological product, or device, unless required to do so by law.
- A statement that the patient’s eligibility for hospice care may be withdrawn if the patient begins treatment, and that hospice care may be reinstated if treatment ends and the patient meets hospice eligibility requirements.
- A statement that the patient understands he or she is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that liability extends to the patient’s estate, unless negotiated otherwise.<sup>51</sup>

The RTTA specifies that there is no obligation on the part of any manufacturer to provide a requested investigational drug, biologic product, or device, but that a manufacturer may do so with or without compensation.<sup>52</sup> The eligible patient may be required to pay the costs of, or associated with, the manufacture of the investigational drug, biological product, or device.<sup>53</sup> The RTTA allows, but does not require, a health plan, third-party administrator, or governmental agency to cover the cost of an investigational drug, biological product, or device.<sup>54</sup> The RTTA exempts a patient’s heirs from any outstanding debt associated with the patient’s use of the investigational drug, biological product, or device.<sup>55</sup>

The RTTA prohibits the Board of Medicine or Board of Osteopathic Medicine from revoking, suspending, or denying renewal of a physician’s license based solely on the physician’s recommendation to an eligible patient regarding access to or treatment with an investigational drug,

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<sup>49</sup> s. 499.0295(2)(c), F.S.

<sup>50</sup> s. 499.0295(2)(a), F.S.

<sup>51</sup> s. 499.0295(2)(d), F.S.

<sup>52</sup> s. 499.0295(3), F.S.

<sup>53</sup> *Id.*

<sup>54</sup> s. 499.0295(4) and (9), F.S.

<sup>55</sup> s. 499.0295(6), F.S.

biological product, or device. It also prohibits action against a physician's Medicare certification for the same reason.<sup>56</sup>

The RTTA provides liability protection for a manufacturer, person, or entity involved in the use of an investigational drug, biological product, or device in good faith compliance with the provisions of the bill and exercising reasonable care.<sup>57</sup>

### **Effect of Bill**

The bill amends the definition of "investigational drug, biological product, or device" set forth in the RTTA to include cannabis that is manufactured and sold by a dispensing organization that has been approved by DOH under the section. The bill directs DOH to approve, by October 1, 2016, 20 dispensing organizations to cultivate, process, and dispense cannabis. Applicants for such approval must meet the same qualifications required for dispensing organizations under the CMCA, except that such applicants do not have to establish the requirements specified in s. 381.986(5)(b)1, F.S.<sup>58</sup>

The bill further specifies that, notwithstanding the state's laws criminalizing the non-medical use of cannabis:

- Eligible patients under the RTTA or their legal representatives may purchase cannabis from a dispensing organization and may possess such cannabis for the patient's medical use.
- Dispensing organizations and their owners, managers, and employees may manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of cannabis and are not subject to licensing and regulation by the Board of Pharmacy under ch. 465, F.S.

The bill specifies that the terms "manufacture,"<sup>59</sup> "possession,"<sup>60</sup> "deliver,"<sup>61</sup> "distribute,"<sup>62</sup> and "dispense"<sup>63</sup> are defined as provided in s. 893.02, F.S.

Finally, the bill authorizes DOH to adopt rules to administer the subsection addressing the medical use of cannabis.

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<sup>56</sup> s. 499.0295(7), F.S.

<sup>57</sup> s. 499.0295(8), F.S.

<sup>58</sup> Under s. 381.986(5)(b)1., F.S., applicants seeking approval to be a dispensing organization under the CMCA must demonstrate: "The technical and technological ability to cultivate and produce low-THC cannabis. The applicant must possess a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131 that is issued for the cultivation of more than 400,000 plants, be operated by a nurseryman as defined in s. 581.011, and have been operated as a registered nursery in this state for at least 30 continuous years."

<sup>59</sup> Section 893.02(15)(a), F.S., provides that "manufacture" means "the production, preparation, propagation, compounding, cultivating, growing, conversion, or processing of a controlled substance, either directly or indirectly, by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging of the substance or labeling or relabeling of its container, except that this term does not include the preparation, compounding, packaging, or labeling of a controlled substance by: 1. A practitioner or pharmacist as an incident to his or her administering or delivering of a controlled substance in the course of his or her professional practice. 2. A practitioner, or by his or her authorized agent under the practitioner's supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis, and not for sale."

<sup>60</sup> Section 893.02(19), F.S., provides that "possession" includes "temporary possession for the purpose of verification or testing, irrespective of dominion or control."

<sup>61</sup> Section 893.02(6), F.S., provides that "deliver" or "delivery" means "the actual, constructive, or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship."

<sup>62</sup> Section 893.02(8), F.S., provides that "distribute" means "to deliver, other than by administering or dispensing, a controlled substance."

<sup>63</sup> Section 893.02(7), F.S., provides that "dispense" means "the transfer of possession of one or more doses of a medicinal drug by a pharmacist or other licensed practitioner to the ultimate consumer thereof or to one who represents that it is his or her intention not to consume or use the same but to transfer the same to the ultimate consumer or user for consumption by the ultimate consumer or user."

**B. SECTION DIRECTORY:**

Section 1. Amends s. 499.0295, F.S., relating to experimental treatments for terminal conditions.

Section 2. Provides an effective date of July 1, 2016.

**II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT**

**A. FISCAL IMPACT ON STATE GOVERNMENT:**

**1. Revenues:**

The bill does not authorize DOH to impose fees for this purpose.

**2. Expenditures:**

The Office of Compassionate Use (OCU) was required to approve five dispensing organizations by January 1, 2015 upon the passage of the CMCA. In order to implement the CMCA, DOH was appropriated three full time equivalent positions and \$380,472 from the Grants and Donations Trust Fund.<sup>64</sup> The bill requires DOH to approve an additional 20 dispensaries, of which the applicants are not required to meet the specifications in s. 381.986(5)(b)1, F.S.<sup>65</sup> This would cause DOH to experience a significant negative fiscal impact due to the influx of additional applications submitted from an expanded pool of eligible dispensary organizations.

Using the previous need of three positions to support five dispensaries, the additional 20 dispensaries would require four times the positions to support the program. The fiscal impact to DOH would be an additional 12 full time equivalent positions, 437,611 in salary rate, and \$1,299,367 recurring and \$46,584 nonrecurring Grants and Donations Trust Fund budget authority to support these positions and the application process.<sup>66</sup> This analysis includes \$515,200 (four times the current OCU budget of \$128,800) for contracted services required for the application review process.

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

**1. Revenues:**

The bill does not appear to have any impact on local government revenues.

**2. Expenditures:**

The bill does not appear to have any impact on local government expenditures.

**C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

The bill may have a positive fiscal impact on private sector organizations that are approved by DOH to become dispensing organizations.

**D. FISCAL COMMENTS:**

None.

<sup>64</sup> See Specific Appropriation 469A, pg. 101, Ch. 2015-232, Laws of Florida (2015).

<sup>65</sup> *Supra* note 58.

<sup>66</sup> E-mail correspondence Department of Health (February 3, 2016) (on file with Florida House of Representatives Health Care Appropriations Subcommittee).

### III. COMMENTS

#### A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

#### B. RULE-MAKING AUTHORITY:

The bill does not appear to create the need for rulemaking or rulemaking authority.

#### C. DRAFTING ISSUES OR OTHER COMMENTS:

In authorizing the medical use of low-thc cannabis by qualified patients, s.381.986, F.S., the CMCA, establishes a comprehensive regulatory framework that includes: addressing the permissible methods for administering low-thc cannabis; prohibiting the transfer of low-thc cannabis to someone other than the qualified patient; requiring a physician, who has been specially trained, to order the drug for the qualified patient; requiring a qualified patient to execute an informed consent; specifying criminal penalties for physicians who order low-THC cannabis without a reasonable belief that a patient is suffering from an eligible condition and for persons who fraudulently represent such conditions; authorizing DOH to regulate physicians and dispensing organizations to ensure compliance with the CMCA's requirements; and requiring registration and tracking of physicians ordering low-thc cannabis and qualified patients receiving the substance. Such provisions are not set forth in this bill for its authorization of the medical use of cannabis by eligible patients.

### IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On November 17, 2016, the Criminal Justice Subcommittee adopted a substitute amendment and reported the bill favorable as a committee substitute. This amendment defines the term "dispensing organization," requires DOH to approve 20 dispensing organizations by October 1, 2016, and authorizes DOH to adopt rules.

This analysis is drafted to the committee substitute as passed by the Criminal Justice Subcommittee.



27 | that subsection, and subsection (10) is added to that section,  
 28 | to read:

29 |       499.0295 Experimental treatments for terminal conditions.—

30 |       (2) As used in this section, the term:

31 |       (a) "Dispensing organization" means an organization  
 32 | approved by the Department of Health under paragraph (10)(d) to  
 33 | cultivate, process, and dispense cannabis pursuant to this  
 34 | section.

35 |       (c) ~~(b)~~ "Investigational drug, biological product, or  
 36 | device" means:

37 |       1. A drug, biological product, or device that has  
 38 | successfully completed phase 1 of a clinical trial but has not  
 39 | been approved for general use by the United States Food and Drug  
 40 | Administration and remains under investigation in a clinical  
 41 | trial approved by the United States Food and Drug  
 42 | Administration; or

43 |       2. Cannabis that is manufactured and sold by a dispensing  
 44 | organization.

45 |       (10) (a) Notwithstanding s. 893.13, s. 893.135, s. 893.147,  
 46 | or any other provision of law, but subject to the requirements  
 47 | of this section, an eligible patient and the eligible patient's  
 48 | legal representative may purchase cannabis from a dispensing  
 49 | organization and may possess such cannabis for the patient's  
 50 | medical use.

51 |       (b) Notwithstanding s. 381.986, s. 893.13, s. 893.135, s.  
 52 | 893.147, or any other provision of law, but subject to the

53 requirements of this section, a dispensing organization and its  
 54 owners, managers, and employees may manufacture, possess, sell,  
 55 deliver, distribute, dispense, and lawfully dispose of cannabis.

56 (c) A dispensing organization and its owners, managers,  
 57 and employees are not subject to licensure or regulation under  
 58 chapter 465 for manufacturing, possessing, selling, delivering,  
 59 distributing, dispensing, or lawfully disposing of cannabis.

60 (d) By October 1, 2016, the Department of Health shall  
 61 approve the establishment of 20 dispensing organizations to  
 62 cultivate, process, and dispense cannabis pursuant to this  
 63 section. An applicant for approval as a dispensing organization  
 64 must demonstrate it possesses the qualifications specified in s.  
 65 381.986(5)(b)2.-7.

66 (e) As used in this subsection, the terms "manufacture,"  
 67 "possession," "deliver," "distribute," and "dispense" have the  
 68 same meanings as provided in s. 893.02.

69 (f) The Department of Health may adopt rules to administer  
 70 this subsection.

71 Section 2. This act shall take effect July 1, 2016.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___	(Y/N)
ADOPTED AS AMENDED	___	(Y/N)
ADOPTED W/O OBJECTION	___	(Y/N)
FAILED TO ADOPT	___	(Y/N)
WITHDRAWN	___	(Y/N)
OTHER	_____	

1 Committee/Subcommittee hearing bill: Health Care Appropriations  
2 Subcommittee

3 Representative Gaetz offered the following:

4  
5 **Amendment (with title amendment)**

6 Remove everything after the enacting clause and insert:

7 Section 1. Paragraph (b) of subsection (2) of section  
8 499.0295, Florida Statutes, is amended, and subsection (10) is  
9 added to that section, to read:

10 499.0295 Experimental treatments for terminal conditions.—

11 (2) As used in this section, the term:

12 (b) "Investigational drug, biological product, or device"  
13 means:

14 1. A drug, biological product, or device that has  
15 successfully completed phase 1 of a clinical trial but has not  
16 been approved for general use by the United States Food and Drug  
17 Administration and remains under investigation in a clinical

Amendment No. 1

18 trial approved by the United States Food and Drug  
19 Administration; or

20 2. Cannabis that is manufactured and sold by a dispensing  
21 organization licensed under s. 381.986.

22 (10) (a) Notwithstanding s. 893.13, s. 893.135, s. 893.147,  
23 or any other provision of law, but subject to the requirements  
24 of this section, an eligible patient and the eligible patient's  
25 legal representative may purchase and possess cannabis for the  
26 patient's medical use.

27 (b) Notwithstanding s. 381.986, s. 893.13, s. 893.135, s.  
28 893.147, or any other provision of law, but subject to the  
29 requirements of this section, an approved dispensing  
30 organization licensed under s. 381.986 and its owners, managers,  
31 and employees may manufacture, possess, sell, deliver,  
32 distribute, dispense, and lawfully dispose of cannabis.

33 (c) An approved dispensing organization licensed under s.  
34 381.986 and its owners, managers, and employees are not subject  
35 to licensure or regulation under chapter 465 for manufacturing,  
36 possessing, selling, delivering, distributing, dispensing, or  
37 lawfully disposing of cannabis.

38 (d) As used in this subsection, the terms "manufacture,"  
39 "possession," "deliver," "distribute," and "dispense" have the  
40 same meanings as provided in s. 893.02.

41 (e) This section does not impair the license of an  
42 approved dispensing organization under s. 381.986.

43 Section 2. This act shall take effect July 1, 2016.

Amendment No. 1

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

Remove everything before the enacting clause and insert:  
An act relating to experimental treatments for terminal conditions; amending s. 499.0295, F.S.; revising the definition of the term "investigational drug, biological product, or device"; providing for eligible patients to purchase and possess cannabis for medical use; authorizing certain licensed dispensing organizations to manufacture, possess, sell, deliver, distribute, dispense, and dispose of cannabis; exempting such organizations from specified laws; providing applicability; providing an effective date.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 599 Child Welfare  
**SPONSOR(S):** Children, Families & Seniors Subcommittee, Combee  
**TIED BILLS:** IDEN./SIM. BILLS: SB 7018

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	12 Y, 0 N, As CS	Tuszynski	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine 	Pridgeon 
3) Health & Human Services Committee			

### SUMMARY ANALYSIS

Chapter 39, F.S., creates the dependency system, which is charged with child welfare. Child welfare services aim to prevent abandonment, abuse, and neglect of children. The Department of Children and Families' (DCF) Office of Child Welfare works in partnership with local communities and the courts to ensure the safety, timely permanency and well-being of children. DCF contracts for foster care placement and related services with lead agencies, also known as community-based care organizations.

DCF's new practice model seeks to achieve the goals of safety, permanency, child well-being, and family well-being. DCF is required to administer a system of care that prevents the separation of children from their families and provides interventions to allow children to remain safely in their own homes. However, when it is determined that in-home services are not enough to allow a child to safely remain in his or her home, the child is removed from his or her home and placed with a safe and appropriate temporary out-of-home placement.

CS/HB 599 requires lead agencies to provide a continuum of care through direct provision, subcontract, referral, or other effective means, and requires DCF to specify the minimum services available through contract. The bill details the intervention services to be provided by the lead agencies. The bill requires a workgroup to determine the feasibility of a statewide initial assessment tool for placement and services.

The bill requires a quality rating system for group homes and foster homes to be developed by June 30, 2017, and implemented by July 1, 2018. The bill requires DCF to monitor residential group home placements and for lead agencies to develop a plan for managing group home utilization, including specific targets for reductions over a five-year period if the CBC has utilization over 8%. DCF is to report annually on the plans' implementation. The bill creates permanency teams that are required to review out-of-home placements for children placed in residential group care.

The bill makes specific conforming changes to align statute with the new language and practice of the safety methodology, such as:

- Extending jurisdiction for children older than 18 years of age until the age of 22 for young adults having a disability;
- Moving the provisions relating to 'maintaining and strengthening' the placement from the case planning sections of statute to s. 39.621, F.S., making them permanency goals;
- Requiring a transition plan to be approved by the child's 18<sup>th</sup> birthday; and
- Changing the standard for the court to return a child to the home.

The bill also:

- Revises the designation of an agency that is allowed to access confidential records to conform with practice;
- Makes conforming cross reference changes; and
- Repeals obsolete sections of law dealing with residential group care.

The bill has an indeterminate fiscal impact, but costs will be mitigated by funding provided in the House proposed General Appropriations Act for Fiscal Year 2016-17 (See Fiscal Comments section).

The bill provides for an effective date of July 1, 2016.

**This document does not reflect the intent or official position of the bill sponsor or House of Representatives.**

**STORAGE NAME:** h0599c.HCAS.DOCX

**DATE:** 1/26/2016

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### **Present Situation**

##### The Child Welfare System

Chapter 39, F.S., creates the dependency system, which is charged with child welfare. Child welfare services aim to prevent abandonment, abuse, and neglect of children.<sup>1</sup> The Department of Children and Families' (DCF) Office of Child Welfare works in partnership with local communities and the courts to ensure the safety, timely permanency and well-being of children.

##### *New Safety Methodology*

In 2013, DCF began implementing a new child welfare practice model that standardizes the approach to safety decision making and risk assessment in determining a child's safety.<sup>2</sup> DCF's practice model seeks to achieve the goals of safety, permanency, child well-being, and family well-being.<sup>3</sup> The methodology emphasizes parent engagement and empowerment and that child welfare professionals have the skills and supervisory support they need to assess child safety.<sup>4</sup> Child welfare professionals use a safety-focused, family-centered, and trauma-informed approach to achieve these goals.<sup>5</sup> Some of the key practices used to achieve these goals are:<sup>6</sup>

- Engaging the family: Build rapport and trust with the family.
- Partner with all involved: Form partnerships with family members and others who support them.
- Plan for child safety: Develop and implement, with the family and other partners, short-term actions to keep the child safe in the home or in out-of-home care.
- Plan for family change: Work with the child, family members, and other team members to identify appropriate interventions and supports necessary to achieve child safety, permanency and well-being.
- Monitor and adapt case plans: Link family members to services and help them navigate formal systems.

The new practice model shifts the focus from the previously used incident-centered practice to a safety-focused and family-centered practice. This means that instead of the system addressing the specific incident that prompted the investigation into the family, DCF looks to treat the family in a more holistic and safety-focused way to keep children in their homes whenever possible.

##### *Community-Based Care Organizations and Services*

DCF contracts for foster care and related services with lead agencies, also known as community-based care organizations (CBCs). The transition to outsourced provision of child welfare services was intended to increase local community ownership of service delivery and design.<sup>7</sup>

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<sup>1</sup> S. 39.001(8), F.S.

<sup>2</sup> The Department of Children and Families, 2013 Year in Review, accessible at: <http://www.dcf.state.fl.us/admin/publications/year-in-review/2013/page19.shtml> (last accessed December 13, 2015).

<sup>3</sup> The Department of Children and Families, Florida's Child Welfare Practice Model, accessible at: <http://www.myflfamilies.com/service-programs/child-welfare/child-welfare-practice-model> (last accessed December 11, 2015).

<sup>4</sup> Supra. at FN 2.

<sup>5</sup> Supra. at FN 3.

<sup>6</sup> Supra. at FN 3.

<sup>7</sup> Community-Based Care, The Department of Children and Families, accessible at <http://www.myflfamilies.com/service-programs/community-based-care> (last viewed December 8, 2015).

DCF, through the CBCs, is required to administer a system of care<sup>8</sup> for children that is directed toward:

- Prevention of separation of children from their families;
- Intervention to allow children to remain safely in their own homes;
- Reunification of families who have had children removed from their care;
- Safety for children who are separated from their families;
- Focus on the well-being of children through emphasis on educational stability and timely health care;
- Permanency; and
- Transition to independence and self-sufficiency.

Statute provides that under this system CBCs are responsible for providing foster care and related services. These services include, but are not limited to, counseling, domestic violence services, substance abuse services, family preservation, emergency shelter, and adoption.<sup>9</sup> The CBC must give priority to services that are evidence-based and trauma informed.<sup>10</sup> CBCs contract with a number of subcontractors for case management and direct care services to children and their families.<sup>11</sup> There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.<sup>12</sup>

### *Dependency Case Process*

When a child is removed from his or her home, a series of dependency court proceedings must occur to adjudicate the child dependent and place him or her in out-of-home care. The process is as follows:

Dependency Proceeding	Description of Process	Controlling Statute
Removal	The child's home is determined to be unsafe, and the child is removed	s. 39.401, F.S.
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The judge determines whether to keep the child out-of-home.	s. 39.401, F.S.
Petition for Dependency	A petition for dependency occurs within 21 days of the shelter hearing. This petition seeks to find the child dependent.	s. 39.501, F.S.
Arraignment Hearing and Shelter Review	An arraignment and shelter review occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Adjudicatory Trial	An adjudicatory trial is held within 30 days of arraignment. This is the trial that the judge determines whether a child is dependent.	s. 39.507, F.S.
Disposition Hearing	Disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews the case plan and placement of the child. The judge orders the case plan for the family and the appropriate placement of the child.	ss. 39. 506 and 39.521, F.S.
Judicial Review Hearings	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.

<sup>8</sup> S. 409.145(1), F.S.

<sup>9</sup> Id.

<sup>10</sup> S. 409.988(3), F.S.

<sup>11</sup> Supra. at FN 7.

<sup>12</sup> Community Based Care Lead Agency Map, The Department of Children and Families, accessible at <http://www.myflfamilies.com/service-programs/community-based-care/cbc-map> (last accessed December 8, 2015).

## *Case Plans*

DCF must develop a case plan with input from all parties to the dependency case that details the problems being addressed as well as the goals, tasks, services, and responsibilities required to ameliorate the concerns of the state.<sup>13</sup> The case plan follows the child from the provision of voluntary services through dependency, or termination of parental rights.<sup>14</sup> Once a child is found dependent, a judge reviews the case plan, and if the judge accepts the case plan as drafted, orders the case plan to be followed.<sup>15</sup>

Section 39.6011, F.S., details the development of the case plan and who must be involved, such as the parent, guardian ad litem, and if appropriate, the child. This section also details what must be in the case plan, such as descriptions of the identified problems, the permanency goal, timelines, and notice requirements.

Section 39.6012, F.S., details the types of tasks and services that must be provided to the parents as well as the type of care that must be provided to the child. The services must be designed to improve the conditions in the home, facilitate the child's safe return to the home, ensure proper care of the child, and facilitate permanency. The case plan must describe each task with which the parent must comply and the services provided that address the identified problem in the home and all available information that is relevant to the child's care.

When determining whether to place a child back into the home he or she was removed from, or whether to move forward with another permanency option, the court uses the case plan to determine whether the parent has complied with the tasks and services to the extent that the safety, well-being, and the physical, mental and emotional health of the child is not endangered by the return of the child to the home.<sup>16</sup>

## Placements of Children in the Child Welfare System

### *In-home with Services*

DCF is required to administer a system of care that prevents the separation of children from their families and provides interventions to allow children to remain safely in their own homes.<sup>17</sup> Protective investigators and CBC case managers can refer families for in-home services to allow a child, who would otherwise be unsafe, to remain in his or her own home.

### *Out-of-Home Care*

When a child protective investigator determines that in-home services are not enough to allow a child to safely remain in his or her home, the investigator removes the child from his or her home and places the child with a safe and appropriate temporary placement. These temporary placements, referred to as out-of-home care, provide housing and services to children until they can return home to their family or achieve permanency with another family through adoption or guardianship.<sup>18</sup>

CBCs must place all children in out-of-home care in the most appropriate available setting after conducting an assessment using child-specific factors.<sup>19</sup> Legislative intent is to place children in a family-like environment when they are removed from their homes. When possible, child protective

<sup>13</sup> Ss, 39.6011 and 39.6012, F.S.

<sup>14</sup> S. 39.01(11), F.S.

<sup>15</sup> S. 39.521, F.S.

<sup>16</sup> S. 39.522, F.S.

<sup>17</sup> Supra. at FN 8.

<sup>18</sup> Office of Program Policy and Government Accountability, Research Memorandum, Florida's Residential Group Care Program for Children in the Child Welfare System (December 22, 2014) (on file with the Children, Families, and Seniors Subcommittee).

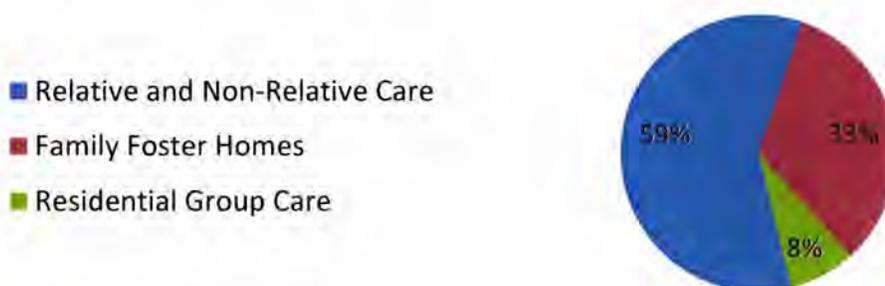
<sup>19</sup> Child-specific factors include age, sex, sibling status, physical, educational, emotional, and developmental needs, maltreatment, community ties, and school placement. (Rule 65C-28.004, F.A.C.)

investigators and lead agency case managers place the children with a relative or responsible adult that the child knows and with whom they have a relationship. These out-of-home placements are referred to as relative and non-relative caregivers. When a relative or non-relative caregiver placement is not possible, case managers try to place the children in family foster homes licensed by DCF.

Some children have extraordinary needs, such as multiple placement disruptions, mental and behavioral health problems, juvenile justice involvement, or children with disabilities, which may require case managers to place them in residential group care. The primary purpose of residential group care is to provide a setting that addresses the unique needs of children and youth who require more intensive services than a family setting can provide.<sup>20</sup>

As of June 1, 2015, there were 21,916 children in out-of-home care.<sup>21</sup>

### Distribution of Children in Out-of-Home Placements FY 2014-15 <sup>22</sup>



#### *Relatives or Non-Relative Caregivers*

Research indicates that children in the care of relatives and non-relatives, such as grandparents or family friends, benefit from increased placement stability and are less likely to change placements as compared to children placed in general foster care. As opposed to children living in foster care, children living in relative and non-relative care are more likely to remain in their own neighborhoods, be placed with their siblings, and have more consistent interactions with their birth parents than do children who are placed in foster care, all of which might contribute to less disruptive transitions into out-of-home care.<sup>23</sup> Relative and non-relative caregivers are not required to be licensed, but do undergo a walk through of their home to determine if the home is appropriate to place the child.

Florida created the Relative Caregiver Program in 1998,<sup>24</sup> to provide financial assistance to eligible relatives caring for children who would otherwise be in the foster care system. The monthly amount of the relative payment is:<sup>25</sup>

- Age zero through five years – \$242
- Age six through 12 years – \$249
- Age 13 to 18 years – \$298

<sup>20</sup> Supra. at FN 18.

<sup>21</sup> Office of Program Policy and Government Accountability, Research Memorandum, Florida's Child Welfare System: Out-of-Home Care (November, 12, 2015) (on file with the Children, Families, and Seniors Subcommittee).

<sup>22</sup> Office of Program Policy and Government Accountability, Research Memorandum, Florida's Child Welfare System: Out-of-Home Care (November, 12, 2015) (on file with the Children, Families, and Seniors Subcommittee).

<sup>23</sup> David Rubin and Downes, K., et al., The Impact of Kinship Care on Behavioral Well-being for Children in Out-of-Home Care (June 2, 2008), available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2654276/> (last accessed December 10, 2015).

<sup>24</sup> S. 39.5085, F.S.

<sup>25</sup> 65C-28.008, F.A.C.

## *Family Foster Homes*

A family foster home means a licensed private residence in which children who are unattended by a parent or legal guardian are provided 24-hour care. Such homes include emergency shelter family homes and specialized foster homes for children with special needs.<sup>26</sup> Foster homes are licensed,<sup>27</sup> inspected regularly, and foster parents go through a rigorous interview process before being approved.<sup>28</sup> Family foster home room and board rates are:<sup>29,30</sup>

- Age zero through five years – \$439.30
- Age six through 12 years – \$450.56
- Age 13 to 21 years – \$527.36

## *Residential Group Care*

Residential group care (RGC) placements are licensed by DCF as residential child-caring agencies<sup>31</sup> that provide staffed 24-hour care for children in facilities maintained for that purpose, regardless of whether operated for profit or whether a fee is charged.<sup>32</sup> These include maternity homes, runaway shelters, group homes, and emergency shelters.<sup>33</sup> The two primary models of group care are the shift model, with staff working in shifts providing 24-hour supervision, and the family model, which has a house parent or parents that live with and are responsible for 24 hour care of children within the group home.<sup>34</sup>

Lead agencies must consider placement in RGC if the following specific criteria are met:

- The child is 11 or older;
- The child has been in licensed family foster care for six months or longer and removed from family foster care more than once; and
- The child has serious behavioral problems or has been determined to be without the options of either family reunification or adoption.<sup>35</sup>

In addition, information from several sources, including psychological evaluations, professionals with knowledge of the child, and the desires of the child concerning placement must be considered.<sup>36</sup> If the lead agency case managers determine that RGC would be an appropriate placement, the child must be placed in RGC if a bed is available. Children who do not meet the specified criteria may be placed in RGC if it is determined that such placement is the most appropriate for the child.<sup>37</sup>

Not only does RGC provide a placement option, it can also serve as a treatment component of the children's mental health system of care.<sup>38</sup> Children in RGC with behavioral health needs receive mental health, substance abuse, and support services that are provided through Medicaid-funded

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<sup>26</sup> S. 409.175, F.S.

<sup>27</sup> Id.

<sup>28</sup> Florida Department of Children and Families, *Fostering Definitions*, available at <http://www.myflfamilies.com/service-programs/foster-care/definitions> (last visited December 9, 2015).

<sup>29</sup> S. 409.145(4), F.S.

<sup>30</sup> Department of Children and Families, *Memorandum on 2015 Foster Parent Cost of Living Allowance Increase (December 31, 2014)* (on file with Children, Families, and Seniors subcommittee staff).

<sup>31</sup> *Supra.* at FN 18.

<sup>32</sup> S. 409.175, F.S.

<sup>33</sup> Id.

<sup>34</sup> *Supra.* at FN 18.

<sup>35</sup> S. 39.523(1), F.S.

<sup>36</sup> Id.

<sup>37</sup> S. 39.523(4), F.S.

<sup>38</sup> Richard Barth, *Institutions vs. Foster Homes: The Empirical Base for the Second Century of Debate*. Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families (June 17, 2002), available at:

[http://www.researchgate.net/publication/237273744\\_vs.\\_Foster\\_Homes\\_The\\_Empirical\\_Base\\_for\\_a\\_Century\\_of\\_Action](http://www.researchgate.net/publication/237273744_vs._Foster_Homes_The_Empirical_Base_for_a_Century_of_Action).

Behavioral Health Overlay Services.<sup>39</sup> Residential group homes also directly employ or contract with therapists and counselors.<sup>40</sup>

Because RGC can be part of a dependent child's mental health system of care they are one of the most expensive placement options for children in the child welfare system. Unlike rates for foster parents and relative caregivers, which are set in statute or by rule, CBCs annually negotiate rates for RGC placements with providers.

During the 2013-2014 fiscal year, the per diem rate for the shift-care group home model averaged \$124, and costs ranged from \$52 to \$283. The per diem rate for a family group home model averaged \$97, and costs ranged from \$17 to \$175. In contrast, family foster homes had an average daily rate of \$15.<sup>41</sup> The total cost of group home care in Florida for the 2014-15 fiscal year was \$89.8 million.<sup>42</sup>

### *Licensure*

DCF is required to license most out-of-home placements, including family foster homes, residential child-caring agencies (residential group care), and child-placing agencies.<sup>43</sup>

The following placements do not require licensure under the licensing statute:

- Relative caregivers,<sup>44</sup>
- Non-relative caregivers,<sup>45</sup>
- An adoptive home which has been approved by the department or by a licensed child-placing agency for children placed for adoption,<sup>46</sup> and
- Persons or neighbors who care for children in their homes for less than 90 days.<sup>47</sup>

Licensure involves meeting rules and regulations pertaining to:

- The operation, conduct, and maintenance of these homes,
- The provision of food, clothing, educational opportunities, services, equipment, and individual supplies to assure the healthy physical, emotional, and mental development of the children served,
- The appropriateness, safety, cleanliness, and general adequacy of the premises, including fire prevention and health standards, to provide for the physical comfort, care, and well-being of the children served,
- The ratio of staff to children required to provide adequate care and supervision of the children served and, in the case of foster homes,
- The maximum number of children in the home, and
- The good moral character based upon screening, education, training, and experience requirements for personnel.<sup>48</sup>

These licensure standards are the minimum requirements that must be met to care for children within the child welfare system. The department must issue a license for those homes and agencies that meet

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<sup>39</sup> Office of Program Policy and Government Accountability, Research Memorandum, Florida's Child Welfare System: Out-of Home Care (November. 12, 2015) (on file with the Children, Families, and Seniors Subcommittee).

<sup>40</sup> *Id.*

<sup>41</sup> *Supra.* at FN 18.

<sup>42</sup> Office of Program Policy and Government Accountability, Research Memorandum, Florida's Child Welfare System: Out-of Home Care (November. 12, 2015) (on file with the Children, Families, and Seniors Subcommittee).

<sup>43</sup> S. 409.175, F.S.

<sup>44</sup> S. 409.175(1)(e), F.S.

<sup>45</sup> *Id.*

<sup>46</sup> S. 409.175(4)(d), F.S.

<sup>47</sup> S. 409.175(1)(e), F.S.

<sup>48</sup> S. 409.175, F.S.

the minimum licensure standards.<sup>49</sup> However, the issuance of a license does not require a lead agency to place a child with any home or agency.<sup>50</sup>

## Residential Group Care Quality Standards

### *Florida Institute for Child Welfare*

The Florida Institute for Child Welfare's (FICW) 2015 Annual Report looked at seven key areas concerning Florida's child welfare system, one of which was residential group care. The report highlighted three recommendations concerning residential group care:

- DCF should continue to refine and implement residential group care quality standards.
- Explore flexible funding that can facilitate higher quality services; and
- Crosswalk quality standards to existing policy and standards to ensure uniformity.

The FICW also published a technical report titled "Improving the Quality of Residential Group Care: A Review of Current Trends, Empirical Evidence, and Recommendations" in July of 2015. This report looked at the current trends and evidence related to residential group care, finding that "[a]lthough the appropriate use of RGC has been a subject of longstanding debate, most child welfare experts, including practitioners, researchers, and advocacy groups, acknowledge that for some youth involved in the child welfare system, high quality group care is an essential and even life saving intervention."<sup>51</sup> Based on reviews of current trends and issues, findings from research, and reviews of recommendations proposed by child welfare experts and advocacy groups the following seven recommendations are offered:<sup>52</sup>

1. Develop and implement a basic set of common quality standards for RGC.
2. Increase evaluation efforts to identify and support evidence-based RGC services.
3. Support RGC providers in strengthening efforts to engage families.
4. Explore innovative approaches, including those that are trauma-informed and relationship-based.
5. Increase efforts to identify and implement culturally competent practices that are supported by research.
6. Continue to build upon efforts to strengthen the child welfare workforce.
7. Explore flexible funding strategies that can help facilitate higher quality services and innovative uses of RGC that are consistent with systems of care principles.

The recommendations made by the FICW focus mainly on quality and implementing strategies to facilitate high quality services within RGC.

### *Group Care Quality Standards Workgroup*

The Group Care Quality Standards Workgroup (workgroup) was established by DCF and the Florida Coalition for Children. The workgroup had representation from group care providers, lead agencies, and DCF and reviewed standards-related literature to determine consensus and ensure a high quality of group care standards.<sup>53</sup> The workgroup identified eight specific category areas for quality standards with 251 distinct quality standards for residential group care.<sup>54</sup>

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<sup>49</sup> S. 409.175(6)(h), F.S.

<sup>50</sup> S. 409.175(6)(i), F.S.

<sup>51</sup> Boel-Studt, S. M. (2015). *Improving the Quality of Residential Group Care: A Review of Current Trends, Empirical Evidence, and Recommendations* (Florida Institute for Child Welfare).

<sup>52</sup> *Id.*

<sup>53</sup> Group Care Quality Standards Workgroup, Quality Standards for Group Care, Florida Department of Children and Families and the Florida Coalition of Children (2015) (on file with Children, Families, and Seniors subcommittee staff).

<sup>54</sup> *Id.*

## Extended Foster Care

In 2014, the Legislature provided foster youth with the ability to extend foster care.<sup>55</sup> Previously, youth did not have the option to remain in foster care after their 18th birthday. Now, through extended foster care, they have the option to remain in care until they turn 21 or, if enrolled in an eligible post-secondary institution, receive financial assistance as they continue pursuing academic and career goals.<sup>56</sup> In extended foster care, young adults continue to receive case management services and other supports to provide them with a sound platform for success as independent adults.

### **Effect of Proposed Changes:**

#### New Safety Methodology

CS/HB 599 makes specific conforming changes to better align statute with the new language and practice of the safety methodology, such as:

- Changing the term 'preventative services' to 'safety management services' as used in practice;
- Moving the provisions relating to 'maintaining and strengthening' the placement from the case planning sections of statute to s. 39.621, F.S., making them permanency goals;
- Requiring a transition plan to be approved by the child's 18<sup>th</sup> birthday;
- Changing time frames for court filings to better align with new practice, giving more time to investigators and case managers to gather and document information on the family;
- Requiring the judicial review social study report to state whether the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home with an in-home safety plan will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health; and
- Changing the standard for the court to return a child to the home from the older incident-based language, "substantially complied with the terms of the case plan" to the new safety-focused language, "circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home with an in-home safety plan will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health."

#### Quality Rating System

The bill requires, by June 30, 2017, that DCF must develop, in collaboration with CBCs, service providers, and other community stakeholders, a statewide quality rating system for providers of residential group care and foster homes. The system must promote high quality in services and accommodations by creating measurable quality standards that providers must meet to contract with CBCs. DCF must submit a report by October 1 of each year that includes a plan for oversight of the implementation of the system, lists providers meeting minimum quality standards, the percentage of children placed with highly rated providers, and any negative actions taken against providers for not meeting minimum quality standards.

#### Group Care Utilization Plan

The bill requires the community-based care lead agencies to develop plans for the management of group care utilization within their services areas by January 1, 2017. These plans must include strategies, action steps, timeframes, and performance measures to manage the use of group care utilization. CBCs with group care utilization above 8% must have a plan that includes specific targets through June 30, 2020, for reduction in use of residential group care to 8%. The plan must maintain

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<sup>55</sup> S. 39.6251, F.S.

<sup>56</sup> The Department of Children and Families, Extended Foster Care – My Future My Choice, *accessible at*: <http://www.myflfamilies.com/service-programs/independent-living/extended-foster-care> (last accessed 12/15/15).

residential group care as an option for out-of-home placement. DCF may allow for different targets for CBCs with extraordinary barriers. DCF must submit an annual report on October 1 of each year beginning in 2017 and continuing through 2022 evaluating the progress of the CBCs.

The bill requires DCF to monitor the use of residential group care as a placement option. The data must differentiate between the use of shift-model group care and family-style group care, the reasons for placement, and strategies to transition children into less restrictive family-like settings. This data must also be incorporated in the results-oriented accountability system and be made available to the Florida Institute for Child Welfare.

The bill also requires the establishment of permanency teams to convene multi-disciplinary staffings to review the appropriateness of placements for children that have been placed in residential group care.

### Assessment

The bill requires DCF, in partnership with the community-based care lead agency, to convene a workgroup to study the feasibility of development and implementation of a statewide initial assessment tool. The tool should assess appropriate placement and initial services for all children placed in out-of-home care. DCF must submit a report by October 1, 2017 that addresses the feasibility of such a tool, and if appropriate, action steps and timeframes for development and implementation.

### Dependency Proceedings

The bill adds a requirement that the social study report for judicial review must include documentation that the placement of the child is in the least restrictive, most family-like setting that meets the needs of the child as determined through assessment.

### Extended Foster Care

The bill continues dependency court jurisdiction for children older than 18 years of age until the age of 22 for young adults having a disability who choose to remain in extended foster care.

### Case Plans

Procedures for involving the child in the case planning process are revised to comply with federal law. These procedures include consulting the child during the case planning process, allowing the child an opportunity to attend a face-to-face case plan conference, if appropriate, and choose two case planning team members. The requirements allow DCF to reject one of these team members if there is good cause to believe that the individual would not act in the best interest of the child.

### Critical Incident Rapid Response Team

The bill requires the CIRRT advisory committee to describe the implementation status of all recommendations from quarterly advisory committee reports within the last 18 months, categorized by the entity to which the recommendation was directed, including any reason for not implementing the recommendation, within the quarterly report it is required to produce.

### Other Changes

The bill also:

- Revises the designation of an agency that is allowed to access confidential records to conform with the licensing statute, s. 409.175, F.S.;
- Requires lead agencies to provide a continuum of care through direct provision, subcontract, referral, or other effective means, and requires DCF to specify the minimum services available through contract;

- Outlines intervention services for unsafe children and the types of services that must be available for eligible individuals;
- Adds specific references to domestic violence services to better align domestic violence services and treatment with the child welfare system; and
- Repeals obsolete sections of law related to residential group care, including provisions dealing with placement in group care, equitable reimbursement for group care services, services required for children with extraordinary needs in group care, and reimbursement methodology.

The bill provides for an effective date of July 1, 2016.

## B. SECTION DIRECTORY:

- Section 1:** Amends s. 39.013, F.S., relating to procedures and jurisdiction.
- Section 2:** Amends s. 39.2015, F.S., relating to critical incident rapid response teams.
- Section 3:** Amends s. 39.402, F.S., relating to placement in shelter.
- Section 4:** Amends s. 39.521, F.S., relating to disposition hearings.
- Section 5:** Amends s. 39.522, F.S., relating to postdisposition change of custody.
- Section 6:** Amends s. 39.6011, F.S., relating to case plan development.
- Section 7:** Amends s. 39.6035, F.S., relating to transition plans.
- Section 8:** Amends s. 39.621, F.S., relating to permanency determination by the court.
- Section 9:** Amends s. 39.701, F.S., relating to judicial review.
- Section 10:** Amends s. 409.145, F.S., relating to care of children; quality parenting; and “reasonable and prudent parent” standard.
- Section 11:** Amends s. 409.1451, F.S., relating to the Road-to-Independence program.
- Section 12:** Amends s. 409.986, F.S., relating to legislative findings and intent; child protection and child welfare outcomes; and definitions.
- Section 13:** Amends s. 409.988, F.S., relating to lead agency duties.
- Section 14:** Amends s. 409.996, F.S., relating to duties of the Department of Children and Families.
- Section 15:** Amends s. 39.01, F.S., relating to definitions
- Section 16:** Amends s. 39.202, F.S., relating to confidentiality of reports and records.
- Section 17:** Amends s. 39.5085, F.S., relating to the relative caregiver program.
- Section 18:** Amends s. 1002.3305, F.S., relating to the college-preparatory boarding academy pilot program for at-risk students.
- Section 19:** Repeals s. 39.523, F.S., relating to placement in group care.
- Section 20:** Repeals s. 409.141, F.S., relating to the equitable reimbursement methodology for nonprofit residential group care services.
- Section 21:** Repeals s. 409.1676, F.S., relating to residential group care services.
- Section 22:** Repeals s. 409.4677, F.S., relating to model comprehensive group care services for children with extraordinary needs.
- Section 23:** Repeals s. 409.1679, F.S., relating to the reimbursement methodology for group care.
- Section 24:** Provides for an effective date of July 1, 2016.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill has an indeterminate fiscal impact on state government. See Fiscal Comments.

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

1. Revenues:

None.

2. Expenditures:

None.

**C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

The bill has an indeterminate fiscal impact on the private sector. See Fiscal Comments.

**D. FISCAL COMMENTS:**

There are multiple provisions in the bill that appear to have an indeterminate fiscal impact upon the department or CBCs; however, the House proposed General Appropriations Act (GAA) for FY 2016-17 includes additional funding specifically for CBCs. These provisions include:

- The requirement that CBCs provide intervention and treatment services to an unsafe child and his or her parent(s) – The House proposed GAA includes \$8.9 million to CBCs for safety management services, which include behavior management, crisis management, resource support and other services to keep a child in the home.
- The requirement that CBCs develop group home utilization assessments – The House proposed GAA includes \$14.8 million to CBCs for core service functions, which would include the administrative functions to create such assessment.
- The new data requirements for inclusion in the social study report for judicial review – The House proposed GAA includes \$6.7 million for enhancements to the Florida Safe Family Network (FSFN) information system that collects socio-demographic data on children in care.

The bill establishes permanency teams to meet every 180 days to reassess the appropriateness of the child's placement and services. It is expected the CBCs will develop the teams locally, but the department's office of Children's Legal Services may have to travel and may experience a workload increase. Based upon a review of budgetary reversions, the department can absorb these costs within existing resources.

The bill requires court review of the child's transition plan prior to the child's 18<sup>th</sup> birthday. Currently, a transition plan must be completed during the 180 period after the child reaches age 17. Since a judicial review of the child's case is required every six months, this provision should have a minimal fiscal impact on the court system.

**III. COMMENTS**

**A. CONSTITUTIONAL ISSUES:**

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

**B. RULE-MAKING AUTHORITY:**

The bill grants rule making authority to create a continuum of care, as well as create, implement and monitor the residential group care utilization plan.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

**IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

On January 20, 2016, the Children, Families and Seniors Subcommittee adopted a strike-all amendment. The amendment made the following changes:

- Provides for alignment of statutory language and standards with DCF's safety methodology; Requires the Critical Incident Rapid Response advisory committee to include in its quarterly reports updates on the implementation status of recommendations;
- Requires lead agencies to provide a continuum of care through direct provision, subcontract, referral, or other effective means, and requires DCF to specify the minimum services available through contract;
- Specifies the intervention services CBC's are to make available;
- Removes the requirement to develop and implement a two-pronged assessment for placement and services, and creates a workgroup to evaluate whether the state should develop an *initial assessment* to help make appropriate initial placements;
- Clarifies and updates case planning requirements to add new federal requirements for children's involvement in case planning under certain circumstances;
- Requires a quality rating system for group homes and foster homes to be developed by June 30, 2017, and implemented by July 1, 2018;
- Requires CBC's to do a plan for managing group home utilization, including specific targets for reductions over a five-year period if the CBC has utilization over 8%;
- Revises the definition of "Permanency Goal" to remove language that is already elsewhere in substantive law; and
- Removes the requirement for education and training vouchers as these programs already exist.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.



27 | s. 39.701, F.S.; revising criteria for review hearings  
 28 | for children younger than 18 years of age; revising  
 29 | criteria for a court to determine in-home or out-of-  
 30 | home placement of a child; amending s. 409.145, F.S.;  
 31 | requiring a workgroup to study the feasibility of a  
 32 | statewide initial assessment for placement and  
 33 | services; requiring the department to submit a report  
 34 | to the Governor and Legislature by a specified date;  
 35 | amending s. 409.1451, F.S.; requiring a child within a  
 36 | specified age range to be living in licensed care as a  
 37 | condition for receiving aftercare services; amending  
 38 | s. 409.986, F.S.; revising the definition of the term  
 39 | "care" to include intervention services; amending s.  
 40 | 409.988, F.S.; requiring lead agencies to provide a  
 41 | continuum of care; defining the term "continuum of  
 42 | care"; requiring specified intervention services;  
 43 | requiring the establishment of permanency teams for  
 44 | certain children to provide specified services;  
 45 | requiring lead agencies to develop residential group  
 46 | care utilization plans by a specified date; requiring  
 47 | the department to monitor lead agency plans and submit  
 48 | an annual report pertaining thereto to the Governor  
 49 | and Legislature; authorizing the department to adopt  
 50 | rules; amending s. 409.996, F.S.; requiring the  
 51 | department to develop and ensure the provision of an  
 52 | adequate array of child-protection services; requiring

53 the department and lead agencies to monitor  
 54 residential group care placements; requiring the  
 55 development and implementation of a statewide quality  
 56 rating system by a specified date; requiring the  
 57 rating system to include specified information;  
 58 requiring the department to submit a report to the  
 59 Governor and Legislature by a specified date; amending  
 60 s. 39.01, F.S.; revising the definition of the term  
 61 "permanency goal"; amending s. 39.202, F.S.; changing  
 62 the designation of an entity; amending ss. 39.5085 and  
 63 1002.3305, F.S.; conforming cross-references;  
 64 repealing s. 39.523, F.S., relating to the placement  
 65 of children in residential group care; repealing s.  
 66 409.141, F.S., relating to equitable reimbursement  
 67 methodology; repealing s. 409.1676, F.S., relating to  
 68 comprehensive residential group care services to  
 69 children who have extraordinary needs; repealing s.  
 70 409.1677, F.S., relating to model comprehensive  
 71 residential services programs; repealing s. 409.1679,  
 72 F.S., relating to program requirements and  
 73 reimbursement methodology; providing an effective  
 74 date.

75

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

77

78 Section 1. Subsection (2) of section 39.013, Florida

79 Statutes, is amended to read:

80 39.013 Procedures and jurisdiction; right to counsel.—

81 (2) The circuit court has exclusive original jurisdiction  
 82 of all proceedings under this chapter, of a child voluntarily  
 83 placed with a licensed child-caring agency, a licensed child-  
 84 placing agency, or the department, and of the adoption of  
 85 children whose parental rights have been terminated under this  
 86 chapter. Jurisdiction attaches when the initial shelter  
 87 petition, dependency petition, or termination of parental rights  
 88 petition, or a petition for an injunction to prevent child abuse  
 89 issued pursuant to s. 39.504, is filed or when a child is taken  
 90 into the custody of the department. The circuit court may assume  
 91 jurisdiction over any such proceeding regardless of whether the  
 92 child was in the physical custody of both parents, was in the  
 93 sole legal or physical custody of only one parent, caregiver, or  
 94 some other person, or was not in the physical or legal custody  
 95 of any person when the event or condition occurred that brought  
 96 the child to the attention of the court. When the court obtains  
 97 jurisdiction of any child who has been found to be dependent,  
 98 the court shall retain jurisdiction, unless relinquished by its  
 99 order, until the child reaches 21 years of age, or 22 years of  
 100 age if the child has a disability, with the following  
 101 exceptions:

102 (a) If a young adult chooses to leave foster care upon  
 103 reaching 18 years of age.

104 (b) If a young adult does not meet the eligibility

105 requirements to remain in foster care under s. 39.6251 or  
 106 chooses to leave care under that section.

107 (c) If a young adult petitions the court at any time  
 108 before his or her 19th birthday requesting the court's continued  
 109 jurisdiction, the juvenile court may retain jurisdiction under  
 110 this chapter for a period not to exceed 1 year following the  
 111 young adult's 18th birthday for the purpose of determining  
 112 whether appropriate services that were required to be provided  
 113 to the young adult before reaching 18 years of age have been  
 114 provided.

115 (d) If a petition for special immigrant juvenile status  
 116 and an application for adjustment of status have been filed on  
 117 behalf of a foster child and the petition and application have  
 118 not been granted by the time the child reaches 18 years of age,  
 119 the court may retain jurisdiction over the dependency case  
 120 solely for the purpose of allowing the continued consideration  
 121 of the petition and application by federal authorities. Review  
 122 hearings for the child shall be set solely for the purpose of  
 123 determining the status of the petition and application. The  
 124 court's jurisdiction terminates upon the final decision of the  
 125 federal authorities. Retention of jurisdiction in this instance  
 126 does not affect the services available to a young adult under s.  
 127 409.1451. The court may not retain jurisdiction of the case  
 128 after the immigrant child's 22nd birthday.

129 Section 2. Subsection (11) of section 39.2015, Florida  
 130 Statutes, is amended to read:

131 39.2015 Critical incident rapid response team.—  
 132 (11) The secretary shall appoint an advisory committee  
 133 made up of experts in child protection and child welfare,  
 134 including the Statewide Medical Director for Child Protection  
 135 under the Department of Health, a representative from the  
 136 institute established pursuant to s. 1004.615, an expert in  
 137 organizational management, and an attorney with experience in  
 138 child welfare, to conduct an independent review of investigative  
 139 reports from the critical incident rapid response teams and to  
 140 make recommendations to improve policies and practices related  
 141 to child protection and child welfare services. The advisory  
 142 committee shall meet at least once each quarter and shall submit  
 143 quarterly reports to the secretary. The quarterly reports shall  
 144 ~~which~~ include findings and recommendations and shall describe  
 145 the implementation status of all recommendations contained  
 146 within the advisory committee reports, including an entity's  
 147 reason for not implementing a recommendation, if applicable. The  
 148 secretary shall submit each report to the Governor, the  
 149 President of the Senate, and the Speaker of the House of  
 150 Representatives.

151 Section 3. Paragraphs (f) and (h) of subsection (8) of  
 152 section 39.402, Florida Statutes, are amended to read:

153 39.402 Placement in a shelter.—

154 (8)

155 (f) At the shelter hearing, the department shall inform  
 156 the court of:

157 1. Any identified current or previous case plans  
 158 negotiated under this chapter in any judicial circuit district  
 159 with the parents or caregivers ~~under this chapter~~ and problems  
 160 associated with compliance;

161 2. Any adjudication of the parents or caregivers of  
 162 delinquency;

163 3. Any past or current injunction for protection from  
 164 domestic violence or an order of no contact; and

165 4. All of the child's places of residence during the prior  
 166 12 months.

167 (h) The order for placement of a child in shelter care  
 168 must identify the parties present at the hearing and must  
 169 contain written findings:

170 1. That placement in shelter care is necessary based on  
 171 the criteria in subsections (1) and (2).

172 2. That placement in shelter care is in the best interest  
 173 of the child.

174 3. That continuation of the child in the home is contrary  
 175 to the welfare of the child because the home situation presents  
 176 a substantial and immediate danger to the child's physical,  
 177 mental, or emotional health or safety which cannot be mitigated  
 178 by the provision of safety management ~~preventive~~ services.

179 4. That based upon the allegations of the petition for  
 180 placement in shelter care, there is probable cause to believe  
 181 that the child is dependent or that the court needs additional  
 182 time, which may not exceed 72 hours, in which to obtain and

183 review documents pertaining to the family in order to  
 184 appropriately determine whether placement in shelter care is  
 185 necessary to ensure the child's safety ~~the risk to the child.~~

186 5. That the department has made reasonable efforts to  
 187 prevent or eliminate the need for removal of the child from the  
 188 home. A finding of reasonable effort by the department to  
 189 prevent or eliminate the need for removal may be made and the  
 190 department is deemed to have made reasonable efforts to prevent  
 191 or eliminate the need for removal if:

192 a. The first contact of the department with the family  
 193 occurs during an emergency;

194 b. The appraisal of the home situation by the department  
 195 indicates that the home situation presents a substantial and  
 196 immediate danger to the child's physical, mental, or emotional  
 197 health or safety which cannot be mitigated by the provision of  
 198 preventive services, including issuance of an injunction against  
 199 a perpetrator of domestic violence pursuant to s. 39.504;

200 c. The child cannot safely remain at home, either because  
 201 there are no safety management ~~preventive~~ services, under s.  
 202 409.988(3)(b), that can ensure the health and safety of the  
 203 child or because, even with appropriate and available services  
 204 being provided, the health and safety of the child cannot be  
 205 ensured; or

206 d. The parent or legal custodian is alleged to have  
 207 committed any of the acts listed as grounds for expedited  
 208 termination of parental rights in s. 39.806(1)(f)-(i).

209           6. That the department has made reasonable efforts to keep  
 210 siblings together if they are removed and placed in out-of-home  
 211 care unless such placement is not in the best interest of each  
 212 child. It is preferred that siblings be kept together in a  
 213 foster home, if available. Other reasonable efforts shall  
 214 include short-term placement in a group home with the ability to  
 215 accommodate sibling groups if such a placement is available. The  
 216 department shall report to the court its efforts to place  
 217 siblings together unless the court finds that such placement is  
 218 not in the best interest of a child or his or her sibling.

219           7. That the court notified the parents, relatives that are  
 220 providing out-of-home care for the child, or legal custodians of  
 221 the time, date, and location of the next dependency hearing and  
 222 of the importance of the active participation of the parents,  
 223 relatives that are providing out-of-home care for the child, or  
 224 legal custodians in all proceedings and hearings.

225           8. That the court notified the parents or legal custodians  
 226 of their right to counsel to represent them at the shelter  
 227 hearing and at each subsequent hearing or proceeding, and the  
 228 right of the parents to appointed counsel, pursuant to the  
 229 procedures set forth in s. 39.013.

230           9. That the court notified relatives who are providing  
 231 out-of-home care for a child as a result of the shelter petition  
 232 being granted that they have the right to attend all subsequent  
 233 hearings, to submit reports to the court, and to speak to the  
 234 court regarding the child, if they so desire.

235 Section 4. Paragraph (a) of subsection (1) of section  
 236 39.521, Florida Statutes, is amended, paragraphs (b) through (f)  
 237 of that subsection are redesignated as paragraphs (c) through  
 238 (g), respectively, and a new paragraph (b) is added to that  
 239 subsection, to read:

240 39.521 Disposition hearings; powers of disposition.—

241 (1) A disposition hearing shall be conducted by the court,  
 242 if the court finds that the facts alleged in the petition for  
 243 dependency were proven in the adjudicatory hearing, or if the  
 244 parents or legal custodians have consented to the finding of  
 245 dependency or admitted the allegations in the petition, have  
 246 failed to appear for the arraignment hearing after proper  
 247 notice, or have not been located despite a diligent search  
 248 having been conducted.

249 (a) A written case plan and a predisposition study  
 250 prepared by an authorized agent of the department must be  
 251 approved by the court. The department must file the case plan  
 252 and predisposition study filed with the court, serve a copy of  
 253 the case plan on ~~served upon~~ the parents of the child, and  
 254 provide a copy of the case plan provided to the representative  
 255 of the guardian ad litem program, if the program has been  
 256 appointed, and ~~provided~~ to all other parties:

257 1. Not less than 72 hours before the disposition hearing,  
 258 if the disposition hearing occurs on or after the 60th day after  
 259 the date the child was placed in out-of-home care. All such case  
 260 plans must be approved by the court.

261 2. Not less than 72 hours before the case plan acceptance  
 262 hearing, if the disposition hearing occurs before the 60th day  
 263 after the date the child was placed in out-of-home care and a  
 264 case plan was not submitted pursuant to this paragraph, or ~~if~~  
 265 the court does not approve the case plan at the disposition  
 266 hearing. The case plan acceptance hearing must occur, ~~the court~~  
 267 ~~must set a hearing~~ within 30 days after the disposition hearing  
 268 ~~to review and approve the case plan.~~

269 (b) The court may grant an exception to the requirement  
 270 for a predisposition study by separate order or within the  
 271 judge's order of disposition upon finding that all the family  
 272 and child information required by subsection (2) is available in  
 273 other documents filed with the court.

274 Section 5. Subsection (2) of section 39.522, Florida  
 275 Statutes, is amended to read:

276 39.522 Postdisposition change of custody.—The court may  
 277 change the temporary legal custody or the conditions of  
 278 protective supervision at a postdisposition hearing, without the  
 279 necessity of another adjudicatory hearing.

280 (2) In cases where the issue before the court is whether a  
 281 child should be reunited with a parent, the court shall  
 282 determine whether the circumstances that caused the out-of-home  
 283 placement and issues subsequently identified have been remedied  
 284 ~~parent has substantially complied with the terms of the case~~  
 285 ~~plan~~ to the extent that the return of the child to the home with  
 286 an in-home safety plan will not be detrimental to the child's

287 safety, well-being, and physical, mental, and emotional health  
 288 ~~of the child is not endangered by the return of the child to the~~  
 289 ~~home.~~

290 Section 6. Paragraphs (b) and (c) of subsection (1) of  
 291 section 39.6011, Florida Statutes, are redesignated as  
 292 paragraphs (c) and (d), respectively, and a new paragraph (b) is  
 293 added to that subsection, to read:

294 39.6011 Case plan development.-

295 (1) The department shall prepare a draft of the case plan  
 296 for each child receiving services under this chapter. A parent  
 297 of a child may not be threatened or coerced with the loss of  
 298 custody or parental rights for failing to admit in the case plan  
 299 ~~to~~ of abusing, neglecting, or abandoning a child. Participating  
 300 in the development of a case plan is not an admission to any  
 301 allegation of abuse, abandonment, or neglect, and it is not a  
 302 consent to a finding of dependency or termination of parental  
 303 rights. The case plan shall be developed subject to the  
 304 following requirements:

305 (b) If the child has attained 14 years of age or is  
 306 otherwise of an appropriate age and capacity, the child must:

307 1. Be consulted on the development of the case plan; have  
 308 the opportunity to attend a face-to-face conference, if  
 309 appropriate; express a placement preference; and have the option  
 310 to choose two members of the case planning team who are not a  
 311 foster parent or caseworker for the child.

312 a. An individual selected by a child to be a member of the

313 case planning team may be rejected at any time if there is good  
 314 cause to believe that the individual would not act in the best  
 315 interest of the child. One individual selected by a child to be  
 316 a member of the child's case planning team may be designated to  
 317 be the child's advisor and, as necessary, advocate with respect  
 318 to the application of the reasonable and prudent parent standard  
 319 to the child.

320 b. The child may not be included in any aspect of the case  
 321 planning process when information will be revealed or discussed  
 322 that is of a nature that would best be presented to the child in  
 323 a more therapeutic setting.

324 2. Sign the case plan, unless there is reason to waive the  
 325 child's signature.

326 3. Receive an explanation of the provisions of the case  
 327 plan from the department.

328 4. Be provided a copy of the case plan after it is agreed  
 329 upon and signed, within 72 hours before the disposition hearing  
 330 after jurisdiction attaches and the plan is filed with the  
 331 court.

332 Section 7. Subsection (4) of section 39.6035, Florida  
 333 Statutes, is amended to read:

334 39.6035 Transition plan.—

335 ~~(4) If a child is planning to leave care upon reaching 18~~  
 336 ~~years of age,~~ The transition plan must be approved by the court  
 337 before the child's 18th birthday and must be attached to the  
 338 case plan and updated before each judicial review ~~child leaves~~

339 | ~~care and the court terminates jurisdiction.~~

340 | Section 8. Subsections (2) through (11) of section 39.621,  
 341 | Florida Statutes, are renumbered as subsections (3) through  
 342 | (12), respectively, present subsection (2) is amended, and a new  
 343 | subsection (2) is added to that section, to read:

344 | 39.621 Permanency determination by the court.—

345 | (2) The permanency goal of maintaining and strengthening  
 346 | the placement with a parent may be used in the following  
 347 | circumstances:

348 | (a) If a child has not been removed from a parent, even if  
 349 | adjudication of dependency is withheld, the court may leave the  
 350 | child in the current placement with maintaining and  
 351 | strengthening the placement as a permanency option.

352 | (b) If a child has been removed from a parent and is  
 353 | placed with the parent from whom the child was not removed, the  
 354 | court may leave the child in the placement with the parent from  
 355 | whom the child was not removed with maintaining and  
 356 | strengthening the placement as a permanency option.

357 | (c) If a child has been removed from a parent and is  
 358 | subsequently reunified with that parent, the court may leave the  
 359 | child with that parent with maintaining and strengthening the  
 360 | placement as a permanency option.

361 | ~~(3)-(2)~~ Except as provided in subsection (2), the  
 362 | permanency goals available under this chapter, listed in order  
 363 | of preference, are:

364 | (a) Reunification;

365 (b) Adoption, if a petition for termination of parental  
 366 rights has been or will be filed;

367 (c) Permanent guardianship of a dependent child under s.  
 368 39.6221;

369 (d) Permanent placement with a fit and willing relative  
 370 under s. 39.6231; or

371 (e) Placement in another planned permanent living  
 372 arrangement under s. 39.6241.

373 Section 9. Paragraphs (a) and (d) of subsection (2) of  
 374 section 39.701, Florida Statutes, are amended to read:

375 39.701 Judicial review.—

376 (2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF  
 377 AGE.—

378 (a) Social study report for judicial review.—Before every  
 379 judicial review hearing or citizen review panel hearing, the  
 380 social service agency shall make an investigation and social  
 381 study concerning all pertinent details relating to the child and  
 382 shall furnish to the court or citizen review panel a written  
 383 report that includes, but is not limited to:

384 1. A description of the type of placement the child is in  
 385 at the time of the hearing, including the safety of the child,  
 386 ~~and the continuing necessity for and appropriateness of the~~  
 387 placement, and that the placement is the least restrictive and  
 388 family-like setting available that meets the needs of the child,  
 389 or an explanation of why the placement is not the least  
 390 restrictive and family-like setting available that meets the

391 needs of the child.

392 2. Documentation of the diligent efforts made by all  
 393 parties to the case plan to comply with each applicable  
 394 provision of the plan.

395 3. The amount of fees assessed and collected during the  
 396 period of time being reported.

397 4. The services provided to the foster family or legal  
 398 custodian in an effort to address the needs of the child as  
 399 indicated in the case plan.

400 5. A statement that either:

401 a. The parent, though able to do so, did not comply  
 402 substantially with the case plan, and the agency  
 403 recommendations;

404 b. The parent did substantially comply with the case plan;  
 405 or

406 c. The parent has partially complied with the case plan,  
 407 with a summary of additional progress needed and the agency  
 408 recommendations.

409 6. A statement of whether the circumstances that caused  
 410 the out-of-home placement and issues subsequently identified  
 411 have been remedied to the extent that the return of the child to  
 412 the home with an in-home safety plan will not be detrimental to  
 413 the child's safety, well-being, and physical, mental, and  
 414 emotional health.

415 ~~7.6.~~ A statement from the foster parent or legal custodian  
 416 providing any material evidence concerning the return of the

417 child to the parent or parents.

418 8.7. A statement concerning the frequency, duration, and  
 419 results of the parent-child visitation, if any, and the agency  
 420 recommendations for an expansion or restriction of future  
 421 visitation.

422 9.8. The number of times a child has been removed from his  
 423 or her home and placed elsewhere, the number and types of  
 424 placements that have occurred, and the reason for the changes in  
 425 placement.

426 10.9. The number of times a child's educational placement  
 427 has been changed, the number and types of educational placements  
 428 which have occurred, and the reason for any change in placement.

429 11.10. If the child has reached 13 years of age but is not  
 430 yet 18 years of age, a statement from the caregiver on the  
 431 progress the child has made in acquiring independent living  
 432 skills.

433 12.11. Copies of all medical, psychological, and  
 434 educational records that support the terms of the case plan and  
 435 that have been produced concerning the parents or any caregiver  
 436 since the last judicial review hearing.

437 13.12. Copies of the child's current health, mental  
 438 health, and education records as identified in s. 39.6012.

439 (d) Orders.—

440 1. Based upon the criteria ~~set forth~~ in paragraph (c) and  
 441 the recommended order of the citizen review panel, if any, the  
 442 court shall determine whether ~~or not~~ the social service agency

443 shall initiate proceedings to have a child declared a dependent  
 444 child, return the child to the parent, continue the child in  
 445 out-of-home care for a specified period of time, or initiate  
 446 termination of parental rights proceedings for subsequent  
 447 placement in an adoptive home. Amendments to the case plan must  
 448 be prepared as prescribed in s. 39.6013. If the court finds that  
 449 remaining in the home with an in-home safety plan will not be  
 450 detrimental to the child's safety, well-being, and physical,  
 451 mental, and emotional health ~~the prevention or reunification~~  
 452 ~~efforts of the department will allow the child to remain safely~~  
 453 ~~at home or be safely returned to the home,~~ the court shall allow  
 454 the child to remain in ~~or return to~~ the home after making a  
 455 ~~specific finding of fact that the reasons for the creation of~~  
 456 ~~the case plan have been remedied to the extent that the child's~~  
 457 ~~safety, well-being, and physical, mental, and emotional health~~  
 458 ~~will not be endangered.~~

459         2. The court shall return the child to the custody of the  
 460 parents at any time it determines that the circumstances that  
 461 caused the out-of-home placement and issues subsequently  
 462 identified have been remedied to the extent that the return of  
 463 the child to the home with an in-home safety plan ~~they have~~  
 464 ~~substantially complied with the case plan, if the court is~~  
 465 ~~satisfied that reunification will not be detrimental to the~~  
 466 child's safety, well-being, and physical, mental, and emotional  
 467 health.

468         3. If, in the opinion of the court, the social service

469 agency has not complied with its obligations as specified in the  
 470 written case plan, the court may find the social service agency  
 471 in contempt, shall order the social service agency to submit its  
 472 plans for compliance with the agreement, and shall require the  
 473 social service agency to show why the child could not safely be  
 474 returned to the home of the parents.

475 4. If, at any judicial review, the court finds that the  
 476 parents have failed to demonstrate behavior change ~~substantially~~  
 477 ~~comply with the case plan~~ to the degree that further  
 478 reunification efforts are without merit and not in the best  
 479 interest of the child, on its own motion, the court may order  
 480 the filing of a petition for termination of parental rights,  
 481 whether or not the time period as contained in the case plan for  
 482 substantial compliance has expired.

483 5. Within 6 months after the date that the child was  
 484 placed in shelter care, the court shall conduct a judicial  
 485 review hearing to review the child's permanency goal as  
 486 identified in the case plan. At the hearing the court shall make  
 487 findings regarding the likelihood of the child's reunification  
 488 with the parent or legal custodian within 12 months after the  
 489 removal of the child from the home. If the court makes a written  
 490 finding that it is not likely that the child will be reunified  
 491 with the parent or legal custodian within 12 months after the  
 492 child was removed from the home, the department must file with  
 493 the court, and serve on all parties, a motion to amend the case  
 494 plan under s. 39.6013 and declare that it will use concurrent

495 | planning for the case plan. The department must file the motion  
 496 | within 10 business days after receiving the written finding of  
 497 | the court. The department must attach the proposed amended case  
 498 | plan to the motion. If concurrent planning is already being  
 499 | used, the case plan must document the efforts the department is  
 500 | taking to complete the concurrent goal.

501 |         6. The court may issue a protective order in assistance,  
 502 | or as a condition, of any other order made under this part. In  
 503 | addition to the requirements included in the case plan, the  
 504 | protective order may set forth requirements relating to  
 505 | reasonable conditions of behavior to be observed for a specified  
 506 | period of time by a person or agency who is before the court;  
 507 | and the order may require any person or agency to make periodic  
 508 | reports to the court containing such information as the court in  
 509 | its discretion may prescribe.

510 |         Section 10. Subsection (5) of section 409.145, Florida  
 511 | Statutes, is renumbered as subsection (7), and new subsections  
 512 | (5) and (6) are added to that section, to read:

513 |         409.145 Care of children; quality parenting; "reasonable  
 514 | and prudent parent" standard.—The child welfare system of the  
 515 | department shall operate as a coordinated community-based system  
 516 | of care which empowers all caregivers for children in foster  
 517 | care to provide quality parenting, including approving or  
 518 | disapproving a child's participation in activities based on the  
 519 | caregiver's assessment using the "reasonable and prudent parent"  
 520 | standard.

521           (5) INITIAL ASSESSMENT.—The department, in partnership  
 522 with the community-based care lead agencies, shall convene a  
 523 workgroup to study the feasibility of the development,  
 524 validation, adoption, and use of one or more statewide initial  
 525 assessment tools to determine the appropriate placement, needs  
 526 of, and initial services for all children placed in out-of-home  
 527 care. For purposes of this subsection, the term "out-of-home  
 528 care" means a licensed or nonlicensed setting, arranged and  
 529 supervised by the department or a contracted service provider,  
 530 outside the home of the parent. The workgroup shall include  
 531 representatives from the department, community-based care lead  
 532 agencies, foster parents, the Florida Institute for Child  
 533 Welfare, service providers, and other appropriate organizations  
 534 and shall consider, at a minimum, the following factors:

535           (a) The traumatic and emergent nature of a removal and  
 536 subsequent out-of-home placement;

537           (b) The frequent lack of immediate information available  
 538 during a removal and subsequent out-of-home placement;

539           (c) Reasonable timelines for the collection of actionable  
 540 information and history on the child and family;

541           (d) Tools and processes being used in this state, other  
 542 states, and nationally;

543           (e) The specific behaviors and needs of the child,  
 544 including, but not limited to, any current behaviors exhibited  
 545 by the child which interfere with or limit the child's ability  
 546 to function in less restrictive, family-like settings;

547 (f) The level of intervention services necessary to meet  
 548 the child's specific physical, emotional, psychological,  
 549 educational, and social needs, including any developmental or  
 550 other disability;

551 (g) Information about previous out-of-home placements,  
 552 including circumstances necessitating any moves between  
 553 placements and the recommendations of the former foster families  
 554 or other caregivers, if available;

555 (h) Information related to the placement of any siblings  
 556 of the child;

557 (i) The range of placement options currently available by  
 558 community-based care lead agency, types of children served, and  
 559 the type of information needed to determine whether placement of  
 560 a child is appropriate; and

561 (j) Any service gaps within community-based care lead  
 562 agency service areas for children in out-of-home care.

563 (6) REPORTING REQUIREMENT.—The department shall submit a  
 564 report to the Governor, the President of the Senate, and the  
 565 Speaker of the House of Representatives by October 1, 2017,  
 566 addressing at a minimum:

567 (a) The types of information needed to make an initial  
 568 assessment for placement and services and methods to collect  
 569 that information;

570 (b) Recommended procedures and practices best suited for  
 571 an initial assessment;

572 (c) The assessment tools and procedures currently used to

573 | make the initial assessment of a child's placement and service  
 574 | needs;

575 | (d) Recommendations regarding the development, validation,  
 576 | adoption, and use of a statewide initial assessment for  
 577 | placement and services; and

578 | (e) If the workgroup finds that an initial assessment for  
 579 | placement and services is feasible, action steps and a timeframe  
 580 | for development, validation, adoption, and implementation.

581 | Section 11. Paragraph (a) of subsection (3) of section  
 582 | 409.1451, Florida Statutes, is amended to read:

583 | 409.1451 The Road-to-Independence Program.—

584 | (3) AFTERCARE SERVICES.—

585 | (a) Aftercare services are available to a young adult who  
 586 | was living in licensed care on his or her 18th birthday, ~~has~~  
 587 | ~~reached 18 years of age but~~ is not yet 23 years of age, and is:

- 588 | 1. Not in foster care.  
 589 | 2. Temporarily not receiving financial assistance under  
 590 | subsection (2) to pursue postsecondary education.

591 | Section 12. Paragraph (a) of subsection (3) of section  
 592 | 409.986, Florida Statutes, is amended to read:

593 | 409.986 Legislative findings and intent; child protection  
 594 | and child welfare outcomes; definitions.—

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

597 | (a) "Care" means services of any kind which are designed  
 598 | to facilitate a child remaining safely in his or her own home,

599 returning safely to his or her own home if he or she is removed  
 600 from the home, or obtaining an alternative permanent home if he  
 601 or she cannot remain at home or be returned home. The term  
 602 includes, but is not limited to, prevention, intervention,  
 603 diversion, and related services.

604 Section 13. Subsection (3) of section 409.988, Florida  
 605 Statutes, is amended to read:

606 409.988 Lead agency duties; general provisions.—

607 (3) SERVICES.—Lead agencies shall make available a  
 608 continuum of care. For purposes of this subsection, the term  
 609 "continuum of care" means a range of services, programs, and  
 610 placement options that meet the varied needs of children served  
 611 by, or at risk of being served by, the dependency system. Such  
 612 services may be provided by the lead agency or its  
 613 subcontractors through referral to another organization or  
 614 through other effective means. The department shall specify the  
 615 minimum services that must be available in a lead agency's  
 616 continuum of care through contract.

617 (a) A lead agency must provide dependent children with  
 618 services that are supported by research or that are recognized  
 619 as best practices in the child welfare field. The agency shall  
 620 give priority to the use of services that are evidence-based and  
 621 trauma-informed and may also provide other innovative services,  
 622 including, but not limited to, family-centered and cognitive-  
 623 behavioral interventions designed to mitigate out-of-home  
 624 placements.

625 (b) Intervention services shall be made available to a  
 626 child and the parent of a child who is unsafe but can, with  
 627 services, remain in his or her home, or a child who is placed  
 628 out-of-home and to the nonmaltreating parent or relative or  
 629 nonrelative caregivers with whom an unsafe child is placed.  
 630 Intervention services and supports include:

631 1. Safety management services provided to an unsafe child  
 632 as part of a safety plan which immediately and actively protects  
 633 the child from dangerous threats if the parent or other  
 634 caregiver cannot protect the child, including, but not limited  
 635 to, behavior management, crisis management, social connection,  
 636 resource support, and separation;

637 2. Treatment services provided to a parent or caregiver  
 638 that are used to achieve a fundamental change in behavioral,  
 639 cognitive, and emotional functioning associated with the reason  
 640 that the child is unsafe, including, but not limited to,  
 641 parenting skills training, support groups, counseling, substance  
 642 abuse treatment, mental, and behavioral health services, and  
 643 certified domestic violence center services for survivors of  
 644 domestic violence and their children, and batterers'  
 645 intervention programs that comply with s. 741.325 and other  
 646 intervention services for perpetrators of domestic violence.

647 3. Child well-being services provided to an unsafe child  
 648 that address a child's physical, emotional, developmental, and  
 649 educational needs, including, but not limited to, behavioral  
 650 health services, substance abuse treatment, tutoring,

651 counseling, and peer support; and

652 4. Services provided to nonmaltreating parents or relative  
 653 or nonrelative caregivers to stabilize the child's placement,  
 654 including, but not limited to, transportation, clothing,  
 655 household goods, assistance with housing and utility payments,  
 656 child care, respite care, and assistance connecting families  
 657 with other community-based services.

658 (c) The department or community-based care lead agency  
 659 that places children pursuant to this section shall establish  
 660 permanency teams dedicated to permanency for children placed in  
 661 residential group care. The permanency team shall convene a  
 662 multidisciplinary staffing every 180 calendar days, to coincide  
 663 with the judicial review, to reassess the appropriateness of the  
 664 child's current placement and services. At a minimum, the  
 665 staffing shall be attended by the community-based care lead  
 666 agency, the caseworker for the child, the guardian ad litem, any  
 667 other agency or provider of services for the child, and a  
 668 representative of the residential group care provider. The  
 669 multidisciplinary staffing shall consider, at a minimum, the  
 670 current level of the child's functioning, whether recommended  
 671 services are being provided effectively, any services that would  
 672 enable transition to a less restrictive family-like setting, and  
 673 diligent search efforts to find other permanent living  
 674 arrangements for the child.

675 (d)1. By January 1, 2017, the lead agencies shall develop  
 676 plans for the management of residential group care utilization

677 within their service areas. The plans shall include strategies,  
678 action steps, timeframes, and performance measures and, for lead  
679 agencies whose group home utilization averaged 8 percent or  
680 above for the preceding fiscal year, list specific percentage  
681 targets by fiscal year through June 30, 2020, for reduction in  
682 use of residential group care to that percentage. The department  
683 may allow for a different group home utilization target for a  
684 lead agency with extraordinary barriers to achievement of an 8-  
685 percent group home utilization, such as significant challenges  
686 in developing an adequate supply of high-quality foster homes or  
687 a large number of children whose needs are best met in  
688 residential group care. Strategies may include, but need not be  
689 limited to, increased recruitment of family foster homes,  
690 including homes for children with specific or extraordinary  
691 needs for which an adequate supply of homes is lacking;  
692 increased use of in-home services which avoid removal; and  
693 policies and procedures for identifying the least restrictive,  
694 most appropriate placements for children and transitioning them  
695 into such placements, when appropriate. However, such strategies  
696 must ensure that appropriate residential group care placements  
697 are available, particularly in family-style homes, for those  
698 children for whom it is the best option. These plans shall be  
699 updated annually through January 1, 2022, and submitted to the  
700 department.

701 2. The department shall monitor the community-based care  
702 lead agencies' achievement of the targets and implementation of

703 the strategies in their individual plans and shall submit an  
 704 annual report on October 1 of each year, beginning in 2017 and  
 705 continuing through 2022, evaluating the agencies' progress to  
 706 the Governor, the President of the Senate, and the Speaker of  
 707 the House of Representatives.

708 (e) The department may adopt rules to implement this  
 709 subsection.

710 Section 14. Section 409.996, Florida Statutes, is amended  
 711 to read:

712 409.996 Duties of the Department of Children and  
 713 Families.—The department shall contract for the delivery,  
 714 administration, or management of care for children in the child  
 715 protection and child welfare system. In doing so, the department  
 716 retains responsibility to ensure ~~for~~ the quality of contracted  
 717 services and programs and ~~shall ensure~~ that an adequate array of  
 718 services are available to be delivered in accordance with  
 719 applicable federal and state statutes and regulations.

720 (1) The department shall enter into contracts with lead  
 721 agencies for the performance of the duties by the lead agencies  
 722 pursuant to s. 409.988. At a minimum, the contracts must:

723 (a) Provide for the services needed to accomplish the  
 724 duties established in s. 409.988 and provide information to the  
 725 department which is necessary to meet the requirements for a  
 726 quality assurance program pursuant to subsection (18) and the  
 727 child welfare results-oriented accountability system pursuant to  
 728 s. 409.997.

729 (b) Provide for graduated penalties for failure to comply  
 730 with contract terms. Such penalties may include financial  
 731 penalties, enhanced monitoring and reporting, corrective action  
 732 plans, and early termination of contracts or other appropriate  
 733 action to ensure contract compliance. The financial penalties  
 734 shall require a lead agency to reallocate funds from  
 735 administrative costs to direct care for children.

736 (c) Ensure that the lead agency shall furnish current and  
 737 accurate information on its activities in all cases in client  
 738 case records in the state's statewide automated child welfare  
 739 information system.

740 (d) Specify the procedures to be used by the parties to  
 741 resolve differences in interpreting the contract or to resolve  
 742 disputes as to the adequacy of the parties' compliance with  
 743 their respective obligations under the contract.

744 (2) The department must adopt written policies and  
 745 procedures for monitoring the contract for delivery of services  
 746 by lead agencies which must be posted on the department's  
 747 website. These policies and procedures must, at a minimum,  
 748 address the evaluation of fiscal accountability and program  
 749 operations, including provider achievement of performance  
 750 standards, provider monitoring of subcontractors, and timely  
 751 followup of corrective actions for significant monitoring  
 752 findings related to providers and subcontractors. These policies  
 753 and procedures must also include provisions for reducing the  
 754 duplication of the department's program monitoring activities

755 both internally and with other agencies, to the extent possible.  
 756 The department's written procedures must ensure that the written  
 757 findings, conclusions, and recommendations from monitoring the  
 758 contract for services of lead agencies are communicated to the  
 759 director of the provider agency and the community alliance as  
 760 expeditiously as possible.

761 (3) The department shall receive federal and state funds  
 762 as appropriated for the operation of the child welfare system,  
 763 transmit these funds to the lead agencies as agreed to in the  
 764 contract, and provide information on its website of the  
 765 distribution of the federal funds. The department retains  
 766 responsibility for the appropriate spending of these funds. The  
 767 department shall monitor lead agencies to assess compliance with  
 768 the financial guidelines established pursuant to s. 409.992 and  
 769 other applicable state and federal laws.

770 (4) The department shall provide technical assistance and  
 771 consultation to lead agencies in the provision of care to  
 772 children in the child protection and child welfare system.

773 (5) The department retains the responsibility for the  
 774 review, approval or denial, and issuances of all foster home  
 775 licenses.

776 (6) The department shall process all applications  
 777 submitted by lead agencies for the Interstate Compact on the  
 778 Placement of Children and the Interstate Compact on Adoption and  
 779 Medical Assistance.

780 (7) The department shall assist lead agencies with access

781 to and coordination with other service programs within the  
782 department.

783 (8) The department shall determine Medicaid eligibility  
784 for all referred children and shall coordinate services with the  
785 Agency for Health Care Administration.

786 (9) The department shall develop, in cooperation with the  
787 lead agencies, a third-party credentialing entity approved  
788 pursuant to s. 402.40(3), and the Florida Institute for Child  
789 Welfare established pursuant to s. 1004.615, a standardized  
790 competency-based curriculum for certification training for child  
791 protection staff.

792 (10) The department shall maintain the statewide adoptions  
793 website and provide information and training to the lead  
794 agencies relating to the website.

795 (11) The department shall provide training and assistance  
796 to lead agencies regarding the responsibility of lead agencies  
797 relating to children receiving supplemental security income,  
798 social security, railroad retirement, or veterans' benefits.

799 (12) With the assistance of a lead agency, the department  
800 shall develop and implement statewide and local interagency  
801 agreements needed to coordinate services for children and  
802 parents involved in the child welfare system who are also  
803 involved with the Agency for Persons with Disabilities, the  
804 Department of Juvenile Justice, the Department of Education, the  
805 Department of Health, and other governmental organizations that  
806 share responsibilities for children or parents in the child

807 | welfare system.

808 |       (13) With the assistance of a lead agency, the department  
809 | shall develop and implement a working agreement between the lead  
810 | agency and the substance abuse and mental health managing entity  
811 | to integrate services and supports for children and parents  
812 | serviced in the child welfare system.

813 |       (14) The department shall work with the Agency for Health  
814 | Care Administration to provide each Medicaid-eligible child with  
815 | early and periodic screening, diagnosis, and treatment,  
816 | including 72-hour screening, periodic child health checkups, and  
817 | prescribed followup for ordered services, including, but not  
818 | limited to, medical, dental, and vision care.

819 |       (15) The department shall assist lead agencies in  
820 | developing an array of services in compliance with the Title IV-  
821 | E waiver and shall monitor the provision of such services.

822 |       (16) The department shall provide a mechanism to allow  
823 | lead agencies to request a waiver of department policies and  
824 | procedures that create inefficiencies or inhibit the performance  
825 | of the lead agency's duties.

826 |       (17) The department shall directly or through contract  
827 | provide attorneys to prepare and present cases in dependency  
828 | court and shall ensure that the court is provided with adequate  
829 | information for informed decisionmaking in dependency cases,  
830 | including a face sheet for each case which lists the names and  
831 | contact information for any child protective investigator, child  
832 | protective investigation supervisor, case manager, and case

833 manager supervisor, and the regional department official  
 834 responsible for the lead agency contract. The department shall  
 835 provide to the court the case information and recommendations  
 836 provided by the lead agency or subcontractor. For the Sixth  
 837 Judicial Circuit, the department shall contract with the state  
 838 attorney for the provision of these services.

839 (18) The department, in consultation with lead agencies,  
 840 shall establish a quality assurance program for contracted  
 841 services to dependent children. The quality assurance program  
 842 shall be based on standards established by federal and state law  
 843 and national accrediting organizations.

844 (a) The department must evaluate each lead agency under  
 845 contract at least annually. These evaluations shall cover the  
 846 programmatic, operational, and fiscal operations of the lead  
 847 agency and must be consistent with the child welfare results-  
 848 oriented accountability system required by s. 409.997. The  
 849 department must consult with dependency judges in the circuit or  
 850 circuits served by the lead agency on the performance of the  
 851 lead agency.

852 (b) The department and each lead agency shall monitor out-  
 853 of-home placements, including:

854 1. The extent to which sibling groups are placed together  
 855 or provisions to provide visitation and other contacts if  
 856 siblings are separated. The data shall identify reasons for  
 857 sibling separation. Information related to sibling placement  
 858 shall be incorporated into the results-oriented accountability

859 | system required pursuant to s. 409.997 and into the evaluation  
 860 | of the outcome specified in s. 409.986(2)(e). The information  
 861 | related to sibling placement shall also be made available to the  
 862 | institute established pursuant s. 1004.615 for use in assessing  
 863 | the performance of child welfare services in relation to the  
 864 | outcome specified in s. 409.986(2)(e).

865 |       2. The extent to which residential group care is used as a  
 866 | placement option. The data shall differentiate between the use  
 867 | of shift-model group care and family-style group care  
 868 | placements, reasons for placement in residential group care, and  
 869 | strategies to transition children into less restrictive family-  
 870 | like settings. Information related to residential group care  
 871 | shall be incorporated into the results-oriented accountability  
 872 | system required pursuant to s. 409.997 and shall be made  
 873 | available to the institute established pursuant to s. 1004.615.

874 |       (c) The department shall, to the extent possible, use  
 875 | independent financial audits provided by the lead agency to  
 876 | eliminate or reduce the ongoing contract and administrative  
 877 | reviews conducted by the department. If the department  
 878 | determines that such independent financial audits are  
 879 | inadequate, other audits, as necessary, may be conducted by the  
 880 | department. This paragraph does not abrogate the requirements of  
 881 | s. 215.97.

882 |       (d) The department may suggest additional items to be  
 883 | included in such independent financial audits to meet the  
 884 | department's needs.

885 (e) The department may outsource programmatic,  
 886 administrative, or fiscal monitoring oversight of lead agencies.

887 (f) A lead agency must assure that all subcontractors are  
 888 subject to the same quality assurance activities as the lead  
 889 agency.

890 (19) The department and its attorneys have the  
 891 responsibility to ensure that the court is fully informed about  
 892 issues before it, to make recommendations to the court, and to  
 893 present competent evidence, including testimony by the  
 894 department's employees, contractors, and subcontractors, as well  
 895 as other individuals, to support all recommendations made to the  
 896 court. The department's attorneys shall coordinate lead agency  
 897 or subcontractor staff to ensure that dependency cases are  
 898 presented appropriately to the court, giving consideration to  
 899 the information developed by the case manager and direction to  
 900 the case manager if more information is needed.

901 (20) The department, in consultation with lead agencies,  
 902 shall develop a dispute resolution process so that disagreements  
 903 between legal staff, investigators, and case management staff  
 904 can be resolved in the best interest of the child in question  
 905 before court appearances regarding that child.

906 (21) The department shall periodically, and before  
 907 procuring a lead agency, solicit comments and recommendations  
 908 from the community alliance established in s. 20.19(5), any  
 909 other community groups, or public hearings. The recommendations  
 910 must include, but are not limited to:

911 (a) The current and past performance of a lead agency.

912 (b) The relationship between a lead agency and its  
913 community partners.

914 (c) Any local conditions or service needs in child  
915 protection and child welfare.

916 (22) By June 30, 2017, the department shall develop, in  
917 collaboration with lead agencies, service providers, and other  
918 community stakeholders, a statewide quality rating system for  
919 providers of residential group care and foster homes. This  
920 system must promote high quality in services and accommodations  
921 by creating measureable minimum quality standards that providers  
922 must meet to contract with the lead agencies and that foster  
923 homes must meet to receive placements. Domains addressed by a  
924 quality rating system for residential group care may include,  
925 but not be limited to, admissions, service planning and  
926 treatment planning, living environment, and program and service  
927 requirements. The system must be implemented by July 1, 2018.

928 (a) The rating system shall include:

929 1. Delineated levels of quality that are clearly and  
930 concisely defined, including the domains measured and criteria  
931 that must be met to be placed in each level;

932 2. The number of residential group care staff and foster  
933 home parents who have received child welfare certification  
934 pursuant to s. 402.40;

935 3. Contractual incentives for achieving and maintaining  
936 higher levels of quality; and

937 4. A well-defined process for notice, inspection,  
 938 remediation, appeal, and enforcement.

939 (b) The department shall submit a report to the Governor,  
 940 the President of the Senate, and the Speaker of the House of  
 941 Representatives by October 1 of each year, with the first report  
 942 due October 1, 2016. The report must include an update on the  
 943 development of a statewide quality rating system for residential  
 944 group care, and in 2018 and subsequent years, a list of  
 945 providers meeting minimum quality standards and their quality  
 946 ratings; the percentage of children placed in residential group  
 947 care with highly rated providers; any negative actions taken  
 948 against contracted providers for not meeting minimum quality  
 949 standards; and a plan for department oversight of the  
 950 implementation of the statewide quality rating system for  
 951 residential group care by the community-based lead agencies.

952 Section 15. Subsection (52) of section 39.01, Florida  
 953 Statutes, is amended to read:

954 39.01 Definitions.—When used in this chapter, unless the  
 955 context otherwise requires:

956 (52) "Permanency goal" means the living arrangement  
 957 identified for the child to return to or identified as the  
 958 permanent living arrangement of the child. ~~Permanency goals~~  
 959 ~~applicable under this chapter, listed in order of preference,~~  
 960 ~~are:~~

961 ~~(a) Reunification;~~

962 ~~(b) Adoption when a petition for termination of parental~~

963 ~~rights has been or will be filed;~~  
 964 ~~(e) Permanent guardianship of a dependent child under s.~~  
 965 ~~39.6221;~~  
 966 ~~(d) Permanent placement with a fit and willing relative~~  
 967 ~~under s. 39.6231; or~~  
 968 ~~(e) Placement in another planned permanent living~~  
 969 ~~arrangement under s. 39.6241.~~

970  
 971 The permanency goal is also the case plan goal. If concurrent  
 972 case planning is being used, reunification may be pursued at the  
 973 same time that another permanency goal is pursued.

974 Section 16. Paragraph (s) of subsection (2) of section  
 975 39.202, Florida Statutes, is amended to read:

976 39.202 Confidentiality of reports and records in cases of  
 977 child abuse or neglect.—

978 (2) Except as provided in subsection (4), access to such  
 979 records, excluding the name of the reporter which shall be  
 980 released only as provided in subsection (5), shall be granted  
 981 only to the following persons, officials, and agencies:

982 (s) Persons with whom the department is seeking to place  
 983 the child or to whom placement has been granted, including  
 984 foster parents for whom an approved home study has been  
 985 conducted, the designee of a licensed residential child-caring  
 986 agency defined in s. 409.175 ~~group home described in s. 39.523,~~  
 987 an approved relative or nonrelative with whom a child is placed  
 988 pursuant to s. 39.402, preadoptive parents for whom a favorable

989 preliminary adoptive home study has been conducted, adoptive  
 990 parents, or an adoption entity acting on behalf of preadoptive  
 991 or adoptive parents.

992 Section 17. Paragraph (a) of subsection (2) of section  
 993 39.5085, Florida Statutes, is amended to read:

994 39.5085 Relative Caregiver Program.—

995 (2)(a) The Department of Children and Families shall  
 996 establish and operate the Relative Caregiver Program pursuant to  
 997 eligibility guidelines established in this section as further  
 998 implemented by rule of the department. The Relative Caregiver  
 999 Program shall, within the limits of available funding, provide  
 1000 financial assistance to:

1001 1. Relatives who are within the fifth degree by blood or  
 1002 marriage to the parent or stepparent of a child and who are  
 1003 caring full-time for that dependent child in the role of  
 1004 substitute parent as a result of a court's determination of  
 1005 child abuse, neglect, or abandonment and subsequent placement  
 1006 with the relative under this chapter.

1007 2. Relatives who are within the fifth degree by blood or  
 1008 marriage to the parent or stepparent of a child and who are  
 1009 caring full-time for that dependent child, and a dependent half-  
 1010 brother or half-sister of that dependent child, in the role of  
 1011 substitute parent as a result of a court's determination of  
 1012 child abuse, neglect, or abandonment and subsequent placement  
 1013 with the relative under this chapter.

1014 3. Nonrelatives who are willing to assume custody and care

1015 of a dependent child in the role of substitute parent as a  
 1016 result of a court's determination of child abuse, neglect, or  
 1017 abandonment and subsequent placement with the nonrelative  
 1018 caregiver under this chapter. The court must find that a  
 1019 proposed placement under this subparagraph is in the best  
 1020 interest of the child.

1021  
 1022 The placement may be court-ordered temporary legal custody to  
 1023 the relative or nonrelative under protective supervision of the  
 1024 department pursuant to s. 39.521(1)(c)3. ~~39.521(1)(b)3.~~, or  
 1025 court-ordered placement in the home of a relative or nonrelative  
 1026 as a permanency option under s. 39.6221 or s. 39.6231 or under  
 1027 former s. 39.622 if the placement was made before July 1, 2006.  
 1028 The Relative Caregiver Program shall offer financial assistance  
 1029 to caregivers who would be unable to serve in that capacity  
 1030 without the caregiver payment because of financial burden, thus  
 1031 exposing the child to the trauma of placement in a shelter or in  
 1032 foster care.

1033 Section 18. Subsection (11) of section 1002.3305, Florida  
 1034 Statutes, is amended to read:

1035 1002.3305 College-Preparatory Boarding Academy Pilot  
 1036 Program for at-risk students.—

1037 (11) STUDENT HOUSING.—Notwithstanding s. 409.176 ~~ss-~~  
 1038 ~~409.1677(3)(d) and 409.176~~ or any other provision of law, an  
 1039 operator may house and educate dependent, at-risk youth in its  
 1040 residential school for the purpose of facilitating the mission

1041 | of the program and encouraging innovative practices.  
1042 |       Section 19. Section 39.523, Florida Statutes, is repealed.  
1043 |       Section 20. Section 409.141, Florida Statutes, is  
1044 | repealed.  
1045 |       Section 21. Section 409.1676, Florida Statutes, is  
1046 | repealed.  
1047 |       Section 22. Section 409.1677, Florida Statutes, is  
1048 | repealed.  
1049 |       Section 23. Section 409.1679, Florida Statutes, is  
1050 | repealed.  
1051 |       Section 24. This act shall take effect July 1, 2016.

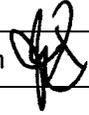


## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1175 Transparency in Health Care

**SPONSOR(S):** Sprowls

**TIED BILLS:** IDEN./SIM. BILLS:

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Affordable Healthcare Access	14 Y, 0 N	Poche	Calamas
2) Health Care Appropriations Subcommittee		Clark 	Pridgeon 
3) Health & Human Services Committee			

### SUMMARY ANALYSIS

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Americans bear a greater share of health care costs, and more participate in high deductible health plans. Clear, accurate information about the cost and quality of health care is necessary for consumers to select value-based health care. HB 1175 ensures greater consumer access to health care price and quality information by requiring certain health care providers, insurers and health maintenance organizations (HMOs) to give that information to patients.

The bill requires the Agency for Health Care Administration (AHCA) to contract with a vendor for an all-payer claims database (APCD), which provides an online, searchable method for patients to compare provider price and quality, and a Florida-specific data set for price and quality research purposes. The bill requires insurers and HMOs to submit data to the APCD, under certain conditions.

The bill creates pre-treatment transparency obligations on hospitals, ambulatory surgery centers, health care practitioners providing non-emergency services in these facilities, and insurers and HMOs.

Specifically, the bill imposes certain pre-treatment transparency requirements. Facilities must post online the average payments and payment ranges received for bundles of health care services defined by the Agency for Health Care Administration (AHCA). This information must be searchable by consumers. Facilities must provide, within 3 days of a request, a good faith, personalized estimate of charges, including facility fees, using bundles of health care services defined by AHCA or patient-specific information. Failure to provide the estimate results in a daily licensure fine of \$1,000. Facilities must inform patients of health care practitioners providing their nonemergency care in hospitals and must provide the same type of estimate, subject to a daily fine of \$500, up to \$5,000. Facilities and facility practitioners must publish information on their financial assistance policies and procedures. Insurers and HMOs must create online methods for patients to estimate their out-of-pocket costs, both using the service bundles established by AHCA and based on patient-specific estimates using the personalized estimate the patient obtains from facilities and practitioners.

Similarly, the bill imposes certain post-treatment transparency requirements. Facilities must provide an itemized bill within 7 days of discharge, meeting certain requirements for comprehension by a layperson, and identifying any providers who may bill separately for the care received in the facility.

The bill requires AHCA to develop standardized culture surveys for hospitals and ambulatory surgery centers, which must conduct the surveys annually and report the results to AHCA for publication.

Finally, the bill makes several changes to the Florida Center for Health Information and Policy Analysis, which is the health care data collection unit of AHCA. The bill changes the Center's name, and streamlines the Center's functions by eliminating obsolete language, redundant duties, and unnecessary functions.

The bill has a significant, negative fiscal impact on AHCA to contract with the APCD vendor and for AHCA to design and process the facility patient safety culture surveys. The bill will require \$952,919 in recurring funds and \$3,100,000 in nonrecurring funds to implement the provisions contained within the bill. The bill will require one full-time equivalent (FTE) position with associated salary rate.

The bill provides an effective date of July 1, 2016.

**This document does not reflect the intent or official position of the bill sponsor or House of Representatives.**

**STORAGE NAME:** h1175b.HCAS.DOCX

**DATE:** 1/21/2016

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### **Background**

##### Health Care Price Transparency

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Americans bear a greater share of health care costs, and more participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data should be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Price transparency in health care can have different definitions. The term can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.<sup>1</sup> Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and identifies a consumer's out-of-pocket cost.<sup>2</sup> Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."<sup>3</sup> Indeed, the definition or the price or cost of health care has different meanings depending on who is incurring the cost.<sup>4</sup>

The annual increase in health care costs has outpaced inflation in every year for the past seven years, except 2008. The following chart shows the increase in costs each year from 2007 through 2014, adjusted and compared against the consumer price index, which is the measure of inflation of the cost of goods and services.<sup>5</sup>

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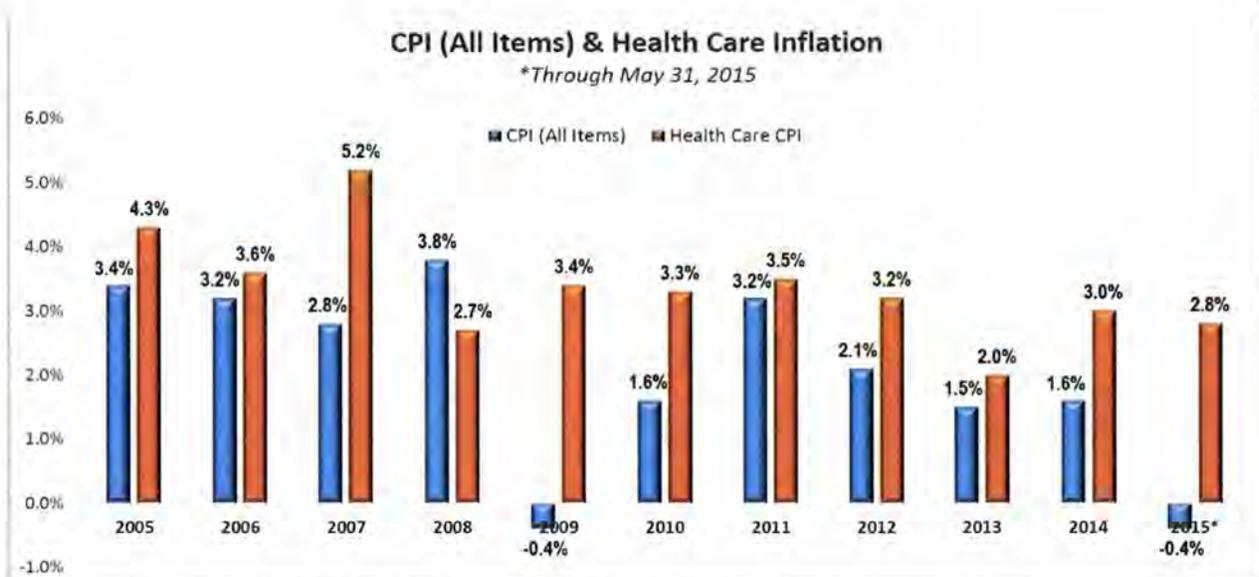
<sup>1</sup> Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at <http://www.gao.gov/products/GAO-11-791>.

<sup>2</sup> Id.

<sup>3</sup> Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, page 2, 2014, available at <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=22279>.

<sup>4</sup> Id.

<sup>5</sup> Patton, M., *U.S. Health Care Costs Rise Faster Than Inflation*, June 29, 2015, available at <http://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-care-costs-rise-faster-than-inflation/> (last viewed January 18, 2016).



Further, PriceWaterhouse Cooper's Health Research Institute projects health care costs to rise 6.5 percent in 2016.<sup>6</sup>

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 out-of-pocket expenses. According to the Kaiser Family Foundation, more than one in five Americans with private insurance is enrolled in a high deductible health plan (HDHP). 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. Eighty-one percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.<sup>7</sup>

Among covered workers with a general annual deductible, the average deductible amount for single coverage is \$1,318.<sup>8</sup> The average annual deductible is similar to last year (\$1,217), but has increased from \$917 in 2010.<sup>9</sup> Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is \$1,836 in small firms, compared to \$1,105 for workers in large firms.<sup>10</sup> Sixty-three percent of covered workers in small firms are in a plan with a deductible of at least \$1,000 for single coverage compared to 39% in large firms; a similar pattern exists for those in plans with a deductible of at least \$2,000 (36% for small firms vs. 12% for large firms)

Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 55% in 2006 to 70% in 2010 to 81% in 2015. If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2015 is \$1,077, up 67% from \$646 in 2010 and 255% from \$303 in 2006.

From 2010 to 2015, the average premium increase for covered workers with family coverage increased 27%, while wages have only increased 10%.<sup>11</sup> Furthermore, 63 percent of covered workers employed by a firm of 3 to 199 employees are in a plan with a deductible of \$1,000 or more, while 39 percent of

<sup>6</sup> PwC, Health Research Institute, *Behind the Numbers*, 2016, available at <http://www.pwc.com/us/en/health-industries/behind-the-numbers.html> (last viewed January 18, 2016).

<sup>7</sup> The Henry J. Kaiser Family Foundation, *2015 Employer Health Benefits Survey*, September 22, 2015, page 4, available at <http://files.kff.org/attachment/report-2015-employer-health-benefits-survey>.

<sup>8</sup> Id.

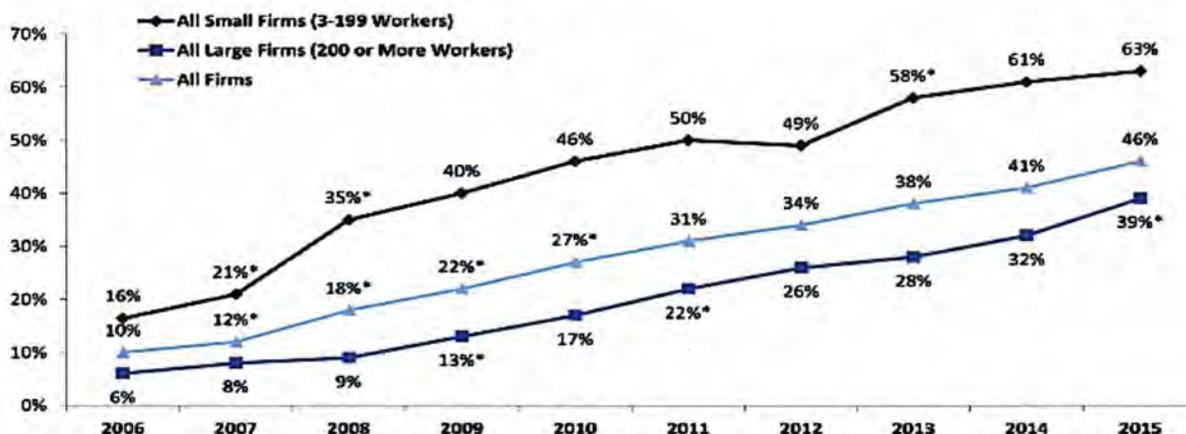
<sup>9</sup> Id.

<sup>10</sup> Id.

<sup>11</sup> Id.

covered workers employed by a firm with 200 or more employees are in such a plan, more than three times the average in 2006.<sup>12</sup> In fact, the average annual deductible in 2015 is \$1,217, up from \$917 in 2010.<sup>13</sup> 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 2006 through 2015.<sup>14</sup>

### Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, By Firm Size, 2006-2015



\* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.



According to the 2014 Mercer National Survey of Employer-Sponsored Health Plans, 48 percent of employers with 500 or more employees currently offer consumer-driven health plans (CDHPs), up from 39 percent in 2013, while 72 percent of jumbo employers, those with 20,000 or more employees, offer CDHPs, up from 63 percent the previous year.<sup>15</sup> Further, more employers plan on offering CDHPs in 2017. The chart below tracks the increase in CDHP offerings over the last five years.<sup>16</sup>

**FIGURE 4**  
Sharp increase in offerings of consumer-directed health plans  
Percent of employers offering/likely to offer CDHP, by employer size

Number of employees	2010	2011	2012	2013	2014	Very likely to offer in 2017
All employers (10+ employees)	17%	20%	22%	23%	27%	36%
All large employers (500+ employees)	23%	32%	36%	39%	48%	66%
Jumbo employers (20,000 + employees)	51%	48%	59%	63%	72%	88%

<sup>12</sup> Id.

<sup>13</sup> Id.

<sup>14</sup> Supra, FN 7, Exhibit G.

<sup>15</sup> Mercer, Newsroom, *Modest Health Benefit Cost Growth Continues as Consumerism Kicks Into High Gear*, November 19, 2014, available at <http://www.mercer.com/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html> (last viewed January 18, 2016).

<sup>16</sup> Id. Mercer National Survey of Employer Sponsored Health Plans.

These trends, coupled with overall increases in health care expenditures, mean consumers now spend \$329.8 billion out-of-pocket annually.<sup>17</sup> Out-of-pocket medical spending by adults with employer-sponsored health insurance rose from \$793 per capita in 2013 to \$810 per capita in 2014.<sup>18</sup> Such spending accounted for 16.3 percent of total per capita health care expenditures in 2014.<sup>19</sup>

### *National Price Transparency Studies*

There are 28 states with active health price transparency or price disclosure legislation.<sup>20</sup> Legislation ranges from requiring facilities and other providers to report prices to state agencies to requiring providers to notify patients and prospective patients of prices of the most common procedures.

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." This report, conducted in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save \$100 billion over ten years.

- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- Expand state-based all-payer health claims databases (APCDs), which could save up to \$55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.<sup>21</sup>

The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated \$18 billion over the next 10 years.<sup>22</sup>

As Americans shoulder more health care costs, research suggests that they are looking for more and better price information.<sup>23</sup>

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<sup>17</sup> U.S. Dept. of Health and Human Services, Centers for Medicaid and Medicare Services, *National Health Expenditure Data Fact Sheet-Historical National Health Expenditures, 2014*, available at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.htm> (last viewed January 18, 2016).

<sup>18</sup> Health Care Cost Institute, *2014 Health Care Cost and Utilization Report*, October 2015, page 5, available at <http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report> (last viewed January 18, 2016).

<sup>19</sup> *Id.*

<sup>20</sup> Pallardy, C., *10 Things to Know About Price Transparency*, Becker's ASCReview, August 25, 2015, available at <http://www.beckersasc.com/asc-coding-billing-and-collections/10-things-to-know-about-price-transparency.html> (last viewed January 18, 2016).

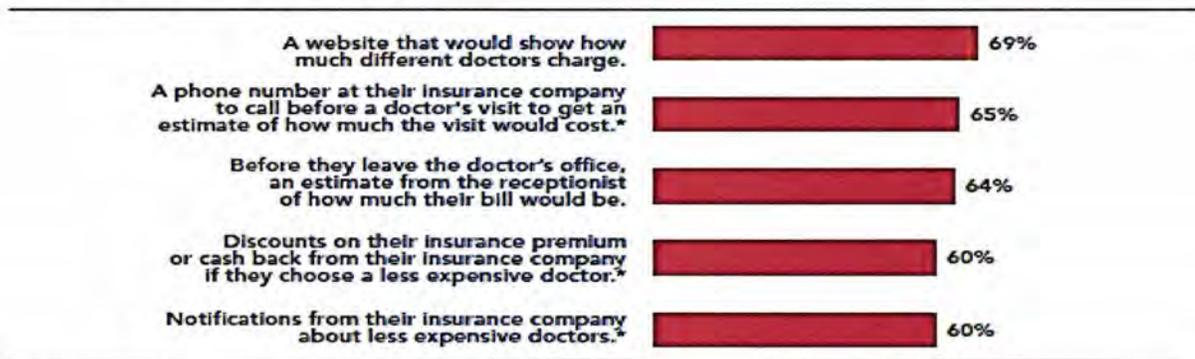
<sup>21</sup> White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, available at: <http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf>.

<sup>22</sup> *Id.* at page 1.

<sup>23</sup> 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 [http://www.publicagenda.org/files/HowMuchWillItCost\\_PublicAgenda\\_2015.pdf](http://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf).

Many Americans want help managing their health care spending.

Figure 16: Percent who say the following resources would help them a lot or some with their health care spending:



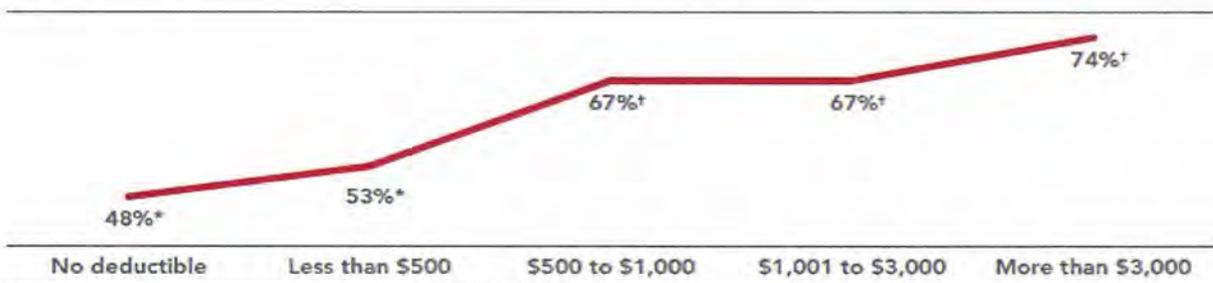
Base: All respondents, N=2,010.

\* Base: Currently have health insurance, n=1,736.

One study in 2014, which conducted a nationally representative 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.<sup>24</sup> The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.<sup>25</sup>

People with deductibles over \$500 are more likely to seek price information.

Figure 2: Percent who say they have tried to find price information before getting care, by deductible amount:



Base: Currently have health insurance, n=1,736.

Estimates for groups indicated by \* are not statistically different from each other, and groups indicated by † are not statistically different from each other; groups indicated by † are statistically different from groups indicated by \* at the p<.05 level.

The individuals who compared prices stated that such research impacted their health care choices and saved them money.<sup>26</sup> In addition, the study found that most Americans do not equate price with quality of care. Seventy one percent do not believe higher price impart a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.<sup>27</sup> Because of the high level of cost-sharing associated with CDHPs, these consumers are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. In fact, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price

<sup>24</sup> Id. at page 3.

<sup>25</sup> Id. at page 13.

<sup>26</sup> Id. at page 4.

<sup>27</sup> Supra, FN 23.

transparency tool.<sup>28</sup> Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.<sup>29</sup>

Additional research has found the use of price transparency tools to be associated with lower total claims payments for common medical services and procedures.<sup>30</sup> A recent study sought the measure the impact of consumer access to health care price data on the cost of three of the most common health services- laboratory tests, advanced imaging services, and clinician office visits.<sup>31</sup> Medical claims from 2010 to 2013 of more than 500,000 patients insured in the U.S. by 18 employers who provided a health care price transparency platform were reviewed to determine the total claims payment for the three services.<sup>32</sup>

Researchers accessed the price transparency platform to determine which claims were associated with a prior search of the platform. In the study sample, 6 percent of lab test claims, 7 percent of advanced imaging claims, and nearly 27 percent of clinician office visit claims were associated with a search.<sup>33</sup> Prior to accessing the price transparency platform, searchers had higher claim payments than non-searchers for each of the services. After using the price transparency platform, searchers paid nearly 14 percent less for lab test services, 13 percent less for advanced imaging services, and 1 percent less for doctor office visits than non-searchers.<sup>34</sup> The study concluded that patient access to pricing information before obtaining clinical services may result in lower overall payments made for clinical care.<sup>35</sup>

### *Florida Efforts in Health Care Price Transparency*

#### Florida Patient's Bill of Rights and Responsibilities

In 1991, s. 381.026, F.S., enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).<sup>36</sup> 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.<sup>37</sup> 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.

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<sup>28</sup> American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, page 4, available at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf402126](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126).

<sup>29</sup> Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, *Health Affairs* 2012; 31(3): 560-568.

<sup>30</sup> Whaley, C., Schneider Chafen, J., et al., *Association Between Availability of Health Service Prices and Payments for These Services*, *Journal of the American Medical Association*. 2014;312(16): 1670-1676.

<sup>31</sup> Id.

<sup>32</sup> Id.

<sup>33</sup> Id.

<sup>34</sup> Id.

<sup>35</sup> Id.

<sup>36</sup> S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.; The Florida Patient's Bill of Rights and Responsibilities is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or health care facility. The rights of patients include standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient's knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient's health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility's rules and regulations affecting patient care and conduct.

<sup>37</sup> S. 381.026(3), F.S.

Under s. 381.026(4)(c), F.S., a patient has the right to request certain financial information from health care providers and facilities.<sup>38</sup> 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.<sup>39</sup> Estimates must be written in language “comprehensible to an ordinary layperson.”<sup>40</sup> 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.<sup>41</sup> A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.<sup>42</sup>

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 Agency’s website.
- 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 Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.<sup>43</sup>

In 2011, the Legislature passed HB 935,<sup>44</sup> which amended the Patient’s Bill of Rights to authorize, but not require, primary care providers<sup>45</sup> to publish a schedule of charges for the medical services offered to patients.<sup>46</sup> The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.<sup>47</sup> 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.<sup>48</sup> 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 2-year period.<sup>49</sup>

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<sup>38</sup> S. 381.026(4)(c), F.S.

<sup>39</sup> S. 381.026(4)(c)3., F.S.

<sup>40</sup> Id.

<sup>41</sup> Id.

<sup>42</sup> S. 381.026(4)(c)5., F.S.

<sup>43</sup> S. 381.0261, F.S.

<sup>44</sup> Ch. 2011-122, Laws of Fla.

<sup>45</sup> 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.

<sup>46</sup> S. 381.026(4)(c)3., F.S.

<sup>47</sup> Id.

<sup>48</sup> Id.

<sup>49</sup> S. 381.026(4)(c)4., F.S.

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.<sup>50</sup> The schedule requirements are the same as those established for primary care providers.<sup>51</sup> 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).<sup>52</sup>

In 2012, the Legislature passed HB 787,<sup>53</sup> which built upon the transparency requirements established by HB 935. The law amended the definition of "urgent care center" to include 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 in the definitions.

The law requires a schedule of charges for medical services posted by an urgent care center to 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. The law also requires the text of the schedule of medical charges to fill at least 12 square feet of the total 15 square feet area of the posted schedule, and allows use of an electronic device for the posting. The device must measure at least three square feet in size and be accessible to all consumers during business hours.

### Health Care Facilities

Under s. 395.301, F.S., a health care facility<sup>54</sup> is required to provide, 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 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 is required to notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 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.

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<sup>50</sup> S. 395.107(1), F.S.

<sup>51</sup> S. 395.107(2), F.S.

<sup>52</sup> In 2012, the Legislature considered, but did not pass, HB 1329. The bill required ambulatory surgical centers and diagnostic-imaging centers to comply with the provisions of s. 395.107, F.S., established by HB 935 in 2011, and required physicians to publish, in writing, a schedule of medical charges. The bill would have imposed a fine of \$1,000, per day, on an urgent care center, ambulatory surgical center, or diagnostic-imaging center that fails to post the schedule of medical charges. The failure of a practitioner to publish and distribute a schedule of medical charges subjected the practitioner to discipline under the applicable practice act and s. 456.072, F.S. Lastly, the bill addressed balance billing by requiring health insurers, hospitals, and medical providers to disclose contractual relationships among the parties and to disclose, in advance of the provision of medical care or services, whether or not the patient will be balance billed as a result of the contractual relationship, or lack thereof, among the insurer, hospital, and medical provider. Failure to provide disclosure to the insured as required by this provision of the bill resulted in a \$500 fine, per occurrence, to be imposed by the AHCA.

<sup>53</sup> SS. 1-3, Ch. 2012-160, Laws of Fla.

<sup>54</sup> The term "health care facilities" refers to hospital, ambulatory surgical centers, and mobile surgical centers, all of which are licensed under part I of Chapter 395, F.S.

## Health Care Quality Transparency

Most Americans believe that the health care they receive is the best available, but the evidence shows otherwise.<sup>55</sup> Although the U.S. spends more than \$3 trillion a year on health care,<sup>56</sup> 17.4 percent of the gross national product,<sup>57</sup> research shows that the quality of health care in America is, at best, imperfect, and, at worst, deeply flawed.<sup>58</sup> Issues with health care quality fall into three categories:

- Underuse. Many patients do not receive medically necessary care.
- Misuse. Each year, more than 100,000 Americans get the wrong care and are injured as a result. More than 1.5 million medication errors are made each year.
- Overuse. Many patients receive care that is not needed or for which there is an equally effective alternative that costs less money or causes fewer side effects.

Research indicates that quality of care in the U.S. is uneven. For example, Americans receive appropriate, evidence-based care when they need it only 55 percent of the time.<sup>59</sup> Similarly, more than 400,000 people die each year as a result of preventable hospital errors in the U.S.<sup>60</sup>, and more than 75,000 people died in 2011 from an infection obtained while in the hospital.<sup>61</sup>

There are hundreds of health care quality measures developed, maintained, and evaluated for relevancy and accuracy by many different organizations, including the federal Agency for Healthcare Research and Quality, the National Quality Forum, and the National Committee for Quality Assurance. In general, health quality measures can be sorted into four categories:<sup>62</sup>

- **Structure measures-** assess the aspects of the health care setting, including facility, personnel, and policies related to the delivery of care.
  - Example- What is the nurse-to-patient ratio in a neonatal intensive care unit?
- **Process measures-** determine if the services provided to patients are consistent with routine clinical care.
  - Example- Does a doctor recommend prostate-specific antigen testing for his male patients at average risk for prostate cancer beginning at age 50?
- **Outcome measures-** evaluate patient health as a result of care received.
  - Example- What is the infection rate of patients undergoing cardiac surgery at a hospital?
- **Patient experience measures-** provide feedback on patients' experiences with the care received.
  - Example- Do patients recommend their doctor to others following a procedure?

Data on health care quality measures come from a number of sources. Some of the most common source include:

<sup>55</sup> National Committee for Quality Assurance, *The Essential Guide to Health Quality*, page 6, available at [http://www.ncqa.org/Portals/0/Publications/Resource/%20Library/NCQA\\_Primer\\_web.pdf](http://www.ncqa.org/Portals/0/Publications/Resource/%20Library/NCQA_Primer_web.pdf) (last viewed January 18, 2016).

<sup>56</sup> The Henry J. Kaiser Foundation, Peterson-Kaiser Health System Tracker, *Health Spending Explorer-U.S. Health Expenditures 1960-2014*, available at <http://www.healthsystemtracker.org/interactive/health-spending-explorer/?display=U.S.%2520%2524%2520Billions&service=Hospitals%252CPhysicians%2520%2526%2520Clinics%252CPrescriptions%2520Drug> (last viewed January 18, 2016).

<sup>57</sup> The World Bank, *Data-United States*, available at <http://data.worldbank.org/country/united-states> (last viewed January 18, 2016).

<sup>58</sup> Supra, FN 55.

<sup>59</sup> McGlynn, E.A., Asch, S.M., et al., *The quality of health care delivered to adults in the United States*, *New England Journal of Medicine*, 348(26): 2635-45, June 2, 2003.

<sup>60</sup> James, J., *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, *Journal of Patient Safety*, 9(3): 122-128 (September 2013).

<sup>61</sup> Centers for Disease Control, *Healthcare-associated infections (HAI), Data and Statistics-HAI Prevalence Survey*, available at <http://www.cdc.gov/HAI/surveillance/index.html> (last viewed January 18, 2016).

<sup>62</sup> U.S. Government Accountability Office, *Health Care Transparency-Actions Needed to Improve Cost and Quality Information for Consumers*, October 2014, pgs. 6-7 (citing quality measure categories established by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality's National Quality Measures Clearinghouse, available at <http://qualitymeasures.ahrq.gov/tutorial/varieties.aspx>).

- Health insurance claims and other administrative documents;
- Disease registries, such as those maintained by the Agency for Toxic Substances and Disease Registry<sup>63</sup> in the Centers for Disease Control and national disease-specific registries, like the National Amyotrophic Lateral Sclerosis (ALS) Registry<sup>64</sup> and the Kaiser Permanente Autoimmune Disorder Registry<sup>65</sup>;
- Medical records; and
- Qualitative data, including information from patient surveys, interviews, and focus groups.<sup>66</sup>

Standardized healthcare performance measures are used by a range of healthcare stakeholders for a variety of purposes. Measures help clinicians, hospitals, and other providers understand whether the care they provide their patients is optimal and appropriate, and if not, where to focus their efforts to improve. Public and private payers also use measures for feedback and benchmarking purposes, public reporting, and incentive-based payment. Lastly, measures are an essential part of making the cost and quality of healthcare more transparent to all, particularly for those who receive care or help make care decisions for loved ones. The Institute of Medicine's six domains of quality—safe, effective, patient-centered, timely, efficient, and equitable—are one way to organize the information.<sup>67</sup> Studies have found patients find effectiveness, safety, and patient-centeredness to be most meaningful in their consideration of health care options.<sup>68</sup>

As more and more health care consumers shop for their health care, value becomes more important than price alone. Determining value means comparing the cost of care with information on the quality or benefit of the service. Presenting health care price information without accompanying quality information leads consumers to assume that high-priced care is high quality care.<sup>69</sup> In fact, there is no evidence of a correlation between cost and quality in health care.<sup>70</sup>

Showing cost and quality information together helps consumers clearly see variation among providers.<sup>71</sup> Further, it helps consumers understand that high costs do not necessarily mean high quality—high-quality care is available without paying the highest price.<sup>72</sup> One way to accomplish this would be to present comparative quality and cost information on one, consumer-friendly website, using several specific measures or scores so multiple metrics can be compared at the same time.<sup>73</sup>

### All-Payer Claims Database (APCD)

An APCD is a computer database, usually created by state mandate, which includes data derived from medical, pharmacy, and dental claims, with eligibility and provider files from private and public payers such as commercial insurance carriers, Medicaid, and Medicare.<sup>74</sup> There are both mandatory and voluntary APCDs, however the majority of APCDs established in the last 10 years are mandatory

<sup>63</sup> For more information, visit [www.atsdr.cdc.gov/](http://www.atsdr.cdc.gov/).

<sup>64</sup> For more information, visit <https://wwwn.cdc.gov/ALS/Default.aspx>.

<sup>65</sup> For more information, visit <https://www.dor.kaiser.org/external/DORExternal/aidr/index.aspx>.

<sup>66</sup> *Supra*, FN 62 at page 11.

<sup>67</sup> Institute of Medicine, *Report: Crossing the Quality Chasm: A New Health System for the 21st Century*, March 1, 2001, available at <http://ion.nationalacademies.org/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf> (last viewed January 18, 2016).

<sup>68</sup> Hibbard, JH, Greene, J, Daniel D., *What is Quality Anyway? Performance Reports That Clearly Communicate to Consumers the Meaning of Quality Care*, *Med. Care Res. Rev.*, 67(3): 275-293 (2010).

<sup>69</sup> *Supra*, FN 23 at page 5.

<sup>70</sup> Carman, KL, Maurer M., et al., *Evidence That Consumers Are Skeptical About Evidence-Based Health Care*, *Health Affairs*, 29(7): 1400-1406 (2010).

<sup>71</sup> American Institute of Research, The Robert Wood Johnson Foundation, *How to Report Cost Data to Promote High-Quality, Affordable Choices: Findings from Consumer Testing*, February 2014, available at [http://www.rwjf.org/content/dam/farm/reports/issue\\_brief/2014/rwjf410706](http://www.rwjf.org/content/dam/farm/reports/issue_brief/2014/rwjf410706) (last viewed January 18, 2016).

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> APCD Council, *All Payer Claims Databases: An Overview*, presentation before the Select Committee on Affordable Healthcare Access, January 11, 2016, slide 3 (on file with Select Committee staff).

reporting initiatives.<sup>75</sup> Information contained in claims data reported to an APCD includes:

- Encrypted social security numbers;
- Patient demographics, such as date of birth, gender, residence, and relationship to subscriber or insured;
- Type of product, such as HMO, POS, or indemnity;
- Diagnosis codes;
- Procedure codes;
- NDC codes;
- Revenue codes;
- Service dates;
- Service provider, including name, tax identification number, payer identification number, specialty code, city, state, and zip code;
- Prescribing physician;
- Plan charges & payments;
- Member cost-sharing responsibilities, such as co-payments, coinsurance, and deductible; and
- Facility type.<sup>76</sup>

Information that is normally not included in claims data reported to an APCD includes:

- Services provided to uninsured
- Denied claims;
- Workers' compensation claims;
- Test results from lab work, imaging, etc.;
- Premium information;
- Capitation fees; and
- Administrative fees.<sup>77</sup>

Twenty states have implemented an APCD, designed to do various things. Most states developed and operate the APCD.<sup>78</sup> Other states were involved in the initial planning stages of the APCD, but delegated day-to-day operations of the database to private not-for-profit entity.<sup>79</sup> Two states, California and Washington, have private, voluntary reporting initiatives. Some of the purposes for which APCDs are being used include:<sup>80</sup>

- Understanding overall and categorical costs for care;<sup>81</sup>
- Creating tools for consumers to determine health care costs and quality;<sup>82</sup>
- Determining the variation in health care costs across states;<sup>83</sup>
- Establishing benchmarks for health care purchasers;<sup>84</sup> and
- Evaluating the medical home model.<sup>85</sup>

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<sup>75</sup> Robert Wood Johnson Foundation, APCD Council, *The Basics of All-Payer Claims Databases, A Primer for States*, January 2014, page 2, available at <https://www.apcdouncil.org/file/31/download?token=b7qtlhRQ> (last viewed January 18, 2016).

<sup>76</sup> Jo Porter, APCD Council, *State Innovations in the Use of APCD Data*, presentation at the National Association of State Health Plans Conference, October 19-21, 2015, slide 5 (on file with Select Committee staff).

<sup>77</sup> Id. at slide 6.

<sup>78</sup> Id. at slide 10; Kansas, Maine, Massachusetts, Maryland, Minnesota, New Hampshire, Oregon, Tennessee, Utah, Vermont, W. Virginia, Rhode Island, Connecticut, New York, and Washington.

<sup>79</sup> Id.; Colorado, Virginia, Arkansas, and Washington (still in implementation).

<sup>80</sup> Id. at slide 16.

<sup>81</sup> Colorado, New Hampshire, Maine, Vermont, Utah, Massachusetts, and Maryland.

<sup>82</sup> Massachusetts, New Hampshire, and Maine.

<sup>83</sup> Colorado, Maine, New Hampshire, and Vermont.

<sup>84</sup> New Hampshire.

<sup>85</sup> Vermont and New Hampshire.

The cost of developing, operating and maintaining an APCD varies greatly across states. For example, Colorado has spent \$6.7 million since 2010 on its APCD, and estimates \$2.7 million in annual operations costs. Kansas projects an operations cost of \$1.2 million to \$1.4 million over a 5-year period. Other states have incurred lower costs for operating an APCD. Tennessee has annual APCD operating costs of \$500,000. Utah uses \$615,000 in General Revenue funds and \$185,000 in federal matching funds each year to fund its APCD. West Virginia has operated its APCD, since 2010, on a total of \$200,000. Reported state APCD funding, for a state with 1.3 million to 1.5 million covered lives, ranges from \$350,000 to establish a basic data system to \$1 million to \$2 million for a more robust data system.<sup>86</sup> Start-up costs may range from \$600,000 to \$2 million, depending on the complexity of the APCD platform.<sup>87</sup>

States have also seen wide variation in the amount of time it takes to establish an operating APCD. Some states, like California, Colorado, New Hampshire, and Oregon, took less than one year to two years to have a functional database. Other states, like Kansas and Rhode Island, required four years to have an operational APCD. Still other states, like Connecticut and New York, passed authorizing legislation in 2011 and 2012, respectively, but are still in the implementation process.

States fund APCDs in a variety of ways.<sup>88</sup> Public APCDs are funded, at least in part, through general appropriations or fee assessments. States have also received grant funding to support the initial phases of APCD development. Some states have been able to use the federal grants to develop their APCD. More recently, states have been successful in securing federal rate review grants, and use part of that funding for APCD development, operation, and maintenance.<sup>89</sup> New Hampshire's APCD is used by its Medicaid program and leverages funding from Medicaid to support it.<sup>90</sup> Many states expect to use data product sales to fund, at least in part, the operation of APCDs into the future. Due to the APCD costs experienced by states, it appears that data sales revenue will not be sufficient to wholly fund operation and maintenance of APCDs over the long term, and other core revenue streams will be necessary to fully fund these databases.<sup>91</sup>

### Health Insurer Regulation

The Florida Office of Insurance Regulation (OIR) regulates the business of insurance in the state, in accordance with the Florida Insurance Code (Code). The Life and Health Unit (Unit) of OIR provides financial oversight of health insurers, health maintenance organizations, and other regulated entities providing health care coverage pursuant to various chapters of the Code:

- Chapter 624, F.S. – Insurance Code: Administration and General Provisions
- Chapter 626, F.S. – Insurance Field Representatives and Operations
- Chapter 627, F.S. – Insurance Rates and Contracts
- Chapter 631, F.S. – Insurer Insolvency; Guaranty of Payment
- Chapter 632, F.S. – Fraternal Benefit Societies
- Chapter 636, F.S. – Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations
- Chapter 641, F.S. – Health Care Service Programs
- Chapter 651, F.S. – Continuing Care Contracts

OIR insurance regulatory activities include licensing, rate and form approval, market conduct review, issuing certificates of authority, ensuring solvency, and administrative supervision. The following chart shows the type and number of each entity in the state:<sup>92</sup>

<sup>86</sup> Multiple telephone conferences between APCD Council staff and Select Committee staff, Fall 2015.

<sup>87</sup> Id.

<sup>88</sup> Supra, FN 75 at pg. 5.

<sup>89</sup> Id.

<sup>90</sup> Id.

<sup>91</sup> Id.

<sup>92</sup> Email correspondence from OIR staff dated November 12, 2015 (on file with Select Committee staff).

Authority Category	Authorities
Health Insurers	442
Third Party Administrators	299
Continuing Care Retirement Communities	63
Discount Medical Plan Organizations	42
Health Maintenance Organizations	35
Fraternal Benefit Societies	36
Prepaid Limited Health Service Organizations/Prepaid Health Clinics	27

## Florida Center for Health Information and Policy Analysis

### *Organization and Function*

The Florida Center for Health Information and Policy Analysis (the Florida Center) provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.<sup>93</sup> The Florida Center is housed within AHCA<sup>94</sup> and is funded through appropriations in the General Appropriations Act, through grants, gifts, and other payments, and through fees charged for services.<sup>95</sup> Offices within the Florida Center, which serve different functions,<sup>96</sup> are:

- Data Collection and Quality Assurance, which collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments.<sup>97</sup>
- Risk Management and Patient Safety, which conducts in-depth analyses of reported incidents to determine what happened and how the facility responded to the incident.<sup>98</sup>
- Data Dissemination and Communication, which maintains AHCA's health information website,<sup>99</sup> provides technical assistance to data users, and creates consumer brochures and other publications.<sup>100</sup>
- Health Information Exchange and Policy Analysis, which monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.<sup>101</sup>

The Florida Center identifies existing health-related data and collects data for use in the information system. The information collected by the Florida Center must include:

<sup>93</sup> S. 408.05(1), F.S.

<sup>94</sup> S. 408.05(1), F.S.

<sup>95</sup> S. 408.05(7), F.S.

<sup>96</sup> Agency for Health Care Administration, *Florida Center for Health Information and Policy Analysis*, available at: <http://ahca.myflorida.com/SCHS/index.shtml> (last viewed January 18, 2016).

<sup>97</sup> Agency for Health Care Administration, *Office of Data Collection & Quality Assurance*, available at: <http://ahca.myflorida.com/schs/DataCollection/DataCollection.shtml> (last viewed January 18, 2016).

<sup>98</sup> Agency for Health Care Administration, *Office of Risk Management and Patient Safety*, available at: <http://ahca.myflorida.com/schs/RiskMgtPubSafety/RiskManagement.shtml> (last viewed January 18, 2016).

<sup>99</sup> [www.FloridaHealthFinder.gov](http://www.FloridaHealthFinder.gov)

<sup>100</sup> Agency for Health Care Administration, *Office of Data Dissemination and Communication*, available at: <http://ahca.myflorida.com/schs/DataD/DataD.shtml> (last viewed January 18, 2016).

<sup>101</sup> Agency for Health Care Administration, *Office of Health Information Exchange and Policy Analysis*, available at: <http://ahca.myflorida.com/schs/HIE/HIE.shtml> (last viewed January 18, 2016).

- The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality;
- The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state;
- Environmental, social, and other health hazards;
- Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status;
- Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities;
- Utilization of health care by type of provider;
- Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care;
- Family formation, growth, and dissolution;
- The extent of public and private health insurance coverage in this state; and
- The quality of care provided by various health care providers.<sup>102</sup>

The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ambulatory surgery center (ASC), emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The data is validated for accuracy and maintained in three major databases: the hospital inpatient database, the ambulatory surgery database, and the emergency department database.<sup>103</sup>

- **The hospital inpatient database** contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data.<sup>104</sup> This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.<sup>105</sup>
- **The ambulatory surgery database** contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories.<sup>106</sup> Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.<sup>107</sup>
- **The emergency department database** collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.<sup>108</sup>

<sup>102</sup> S. 408.05(2), F.S.

<sup>103</sup> Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, *2014 Annual Report*, p. 2, available at:

[https://floridahealthfinderstore.blob.core.windows.net/documents/researchers/documents/FC%20Annual%20Report%202014%20Final%20w%20cover%20-%2016\\_15.pdf](https://floridahealthfinderstore.blob.core.windows.net/documents/researchers/documents/FC%20Annual%20Report%202014%20Final%20w%20cover%20-%2016_15.pdf).

<sup>104</sup> Id., pg. 3.

<sup>105</sup> Id., pg. 4.

<sup>106</sup> Id., pgs. 3-4.

<sup>107</sup> Id., pg. 4.

<sup>108</sup> Id., pgs. 4-5.

In addition to these databases, the Office of Risk Management and Patient Safety collects adverse incident reports from health care providers including, hospitals, ambulatory surgical centers, nursing homes, and assisted living facilities.<sup>109</sup>

### *Reporting*

The Florida Center is required to publish and make available the following reports:

- Member satisfaction surveys;
- Publications providing health statistics on topical health policy issues;
- Publications that provide health status profiles of people in Florida;
- Various topical health statistics publications;
- Results of special health surveys, health care research, and health care evaluations required under s. 408.05, F.S.; and
- An annual report on the Florida Center's activities.<sup>110</sup>

The Florida Center must also provide indexing, abstracting, translation, publication and other services leading to a more effective and timely dissemination of health care statistics. The Florida Center is responsible for conducting a variety of special studies and surveys to expand the health care information and statistics available for policy analyses.<sup>111</sup>

### *Public Access to Data*

The Office of Data Dissemination and Communication, within the Florida Center, makes data collected available to the public in three ways: by updating and maintaining the AHCA's health information website at [www.FloridaHealthFinder.gov](http://www.FloridaHealthFinder.gov), by issuing standard and ad hoc reports, and by responding to requests for de-identified data.<sup>112</sup>

The Florida Center maintains [www.FloridaHealthFinder.gov](http://www.FloridaHealthFinder.gov), which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public which allow easy access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. The website also provides tools to researchers and professionals which allow specialized data queries, but requires users to have some knowledge of medical coding and terminology.<sup>113</sup> Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.<sup>114</sup>

The Center disseminates three standard reports which detail hospital fiscal data including a prior year report, an audited financial statement, and a hospital financial data report. Also, ad hoc reports may be requested for customers looking for very specific information not included on a standard report or for customers who do not wish to purchase an entire data set to obtain information. One example of an ad hoc report would be a request for the average length of stay of patients admitted to a hospital with diabetes as a principle or secondary diagnosis.<sup>115</sup> The Center charges a set fee for standard reports<sup>116</sup> and a variable fee based on the extensiveness of an ad hoc report.<sup>117</sup>

<sup>109</sup> Id.

<sup>110</sup> S. 408.05(5), F.S.

<sup>111</sup> Id.

<sup>112</sup> Supra, FN 106, pgs. 6-9.

<sup>113</sup> Id., pg. 9.

<sup>114</sup> Id., pgs. 9-13.

<sup>115</sup> Id., pgs.8-9.

<sup>116</sup> The price list for purchasing data from the Center is available at

<http://floridahealthfinderstore.blob.core.windows.net/documents/researchers/OrderData/documents/PRICE%20LIST%20Dec2014.pdf> (last viewed January 18, 2016).

<sup>117</sup> Supra, FN 107, pg. 7.

The Center also sells hospital inpatient, ambulatory surgery, and emergency department data to the general public in a non-confidential format. However, the requester must sign a limited set data use agreement which binds the requester to only using the data in a way specified in the agreement. Information not available in these limited data sets include: patient ID number, medical record number, social security number, dates of admission and discharge, visit beginning and end dates, age in days, payer, date of birth, and procedure dates.<sup>118</sup>

The Florida Center is required to provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the Florida Center.<sup>119</sup>

### *Florida Center Administration*

AHCA is required to complete a number of responsibilities related to the information system, in order to produce comparable and uniform health information and statistics for the development of policy recommendations.<sup>120</sup> These responsibilities are listed in statute and include the following:

- Undertake research, development, and evaluation regarding the information system for the purpose of creating comparable health information.
- Coordinate the activities of state agencies involved in the design and implementation of the information system and review the statistical activities of state agencies to ensure that they are consistent with the information system.
- Develop written agreements with local, state, and federal agencies to share health-care-related data.
- Establish by rule the types of data collected, compiled, processed, used, or shared.
- Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data.
- Establish advisory standards to ensure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.
- Prescribe standards for the publication of health-care-related data, which ensure the reporting of accurate, valid, reliable, complete, and comparable data.
- Prescribe standards for the maintenance and preservation of the Florida Center's data.
- Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.
- Develop and implement a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services.
- Administer, manage, and monitor grants to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network.
- Initiate, oversee, manage, and evaluate the integration of healthcare data from each state agency that collects, stores, and reports on health care issues and make the data available to any health care practitioner through a state health information network.<sup>121</sup>

### Patient Safety Culture Surveys

In 2004, the federal Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture, a staff survey designed to help hospitals assess the culture of safety in their

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<sup>118</sup> Id., pgs. 7-8.

<sup>119</sup> S. 408.05(4), F.S.

<sup>120</sup> S. 408.05(3), F.S.

<sup>121</sup> S. 408.05(3), F.S., s. 408.05(4), F.S.

institutions.<sup>122</sup> The survey has since been implemented in hundreds of hospitals across the United States, and in other countries. In 2006, AHRQ developed a comparative database on the survey, comprised of data from U.S. hospitals that administered the survey and voluntarily submitted the data.<sup>123</sup> The database allows hospitals wishing to compare their patient safety culture survey results to those of other hospitals in support of patient safety culture improvement.<sup>124</sup> In 2014, 653 hospitals submitted survey results to the database.<sup>125</sup>

The survey<sup>126</sup> asks respondents to indicate to what degree they agree or disagree with a statement, how often something occurs, or provide a specific number or grade. Excerpts of the survey follow.

- Teamwork Within Units
  - People support one another in this unit.
  - When a lot of work needs to be done quickly, we work together as a team to get the work done.
  - In this unit, people treat each other with respect.
  - When one area in this unit gets really busy, others help out.
- Supervisor/Manager Expectations & Actions Promoting Patient Safety
  - My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
  - My supervisor/manager seriously considers staff suggestions for improving patient safety.
  - Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.
  - My supervisor/manager overlooks patient safety problems that happen over and over.
- Management Support for Patient Safety
  - Hospital management provides a work climate that promotes patient safety.
  - The actions of hospital management show that patient safety is a top priority.
  - Hospital management seems interested in patient safety only after an adverse event happens.
- Communication Openness
  - Staff will freely speak up if they see something that may negatively affect patient care.
  - Staff feel free to question the decisions or actions of those with more authority.
  - Staff are afraid to ask questions when something does not seem right.
- Handoffs & Transitions
  - Things "fall between the cracks" when transferring patients from one unit to another.
  - Important patient care information is often lost during shift changes.
  - Problems often occur in the exchange of information across hospital units.
  - Shift changes are problematic for patients in this hospital.
- Patient Safety Grade- Excellent, Very Good, Acceptable, Poor, Failing
  - Please give your work area/unit in this hospital an overall grade on patient safety.

AHRQ also developed the Ambulatory Surgery Center Survey on Patient Safety Culture in response to interest from ambulatory surgery centers (ASCs) in assessing patient safety culture in their facilities.

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<sup>122</sup> U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*, available at <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html> (last viewed January 18, 2016).

<sup>123</sup> Id.

<sup>124</sup> Id.

<sup>125</sup> U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2014 User Comparative Database Report-Hospital Survey on Patient Safety Culture*, available at <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/2014/index.html> (last viewed January 18, 2016).

<sup>126</sup> The survey is available at <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/resources/hospscanform.pdf>.

This survey is designed specifically for ASC staff and asks for their opinions about the culture of patient safety in their facility.<sup>127</sup>

## **Effect of Proposed Changes**

HB 1175 establishes a Florida-specific APCD, using an existing national database, including an online price calculator for Florida consumers. It also requires hospitals, ASCs, insurers and HMOs to make prices transparent to patients, and make quality data available to them. .

### All-Payer Claims Database

AHCA is directed to contract with a vendor to provide a user-friendly, Internet-based platform which allows a consumer to research and compare the cost of health care services and procedures. The vendor must also establish and maintain a Florida-specific dataset of health care claims information available to the public and any interested party. Access to state-specific data is designed to encourage research and innovation in the delivery and payment of health care in Florida. The bill delineates criteria that the vendor must meet in order to contract with AHCA for the purposes outlined in the bill. The vendor must:

- Be a non-profit research institute qualified to receive Medicare claims data;
- Receive claims data from multiple private insurers nationwide;
- Have a national database consisting of at least 15 billion claim lines of data from multiple payers, including employers with ERISA plans;
- Have a well-developed methodology for analyzing claims data within health care service bundles; and
- Have a bundling methodology available to the public to allow for consistency and comparison of state and national benchmarks with local regions and specific providers.

The patient must be able to search the price information based on specific services or procedures, and using service bundles that compose a whole episode of hospital care. The service bundles must be understandable to an ordinary layperson. Patients must be able to search the information without a password or registration requirement.

To ensure the collection of health claims data, the bill requires each insurer and HMO participating in the State Group Insurance plan or Statewide Medicaid Managed Care to contribute all Florida claims data to the vendor selected by AHCA. Further, the bill requires Medicaid managed care plans to comply with information disclosure and cost calculation requirements in s. 627.6385, F.S., or s. 641.54, F.S., as applicable. Finally, the bill requires the Department of Management Services to make arrangements to contribute State Group Insurance plan claims data to the vendor selected by AHCA and requires each contracted vendor for the State Group plan to do the same.

### Hospital and ASC Transparency Requirements

#### *Pre-Treatment Transparency*

The bill requires hospitals, ASCs, health care practitioners providing non-emergency hospital services, insurers and HMOs to provide patients with information on price and quality prior to treatment.

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<sup>127</sup> The survey is available at <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/resources/ascsurvey.pdf>.

## Hospitals and ASCs

The bill requires every licensed hospital and ASC (facilities) to provide timely and accurate financial information and quality of service measures to prospective and actual patients, or to patients' survivors or legal guardians. State mental health facilities and mobile surgical facilities are exempt from these requirements.

First, each facility must make information on the payments it receives for services available on its websites. The information must be searchable, and use the same format as that used by the APCD, including the descriptive bundles of services and procedures created by the vendor. 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. 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. The facility must also publish on its website information on the facility's financial assistance policy, including any application process, payment plans, discounts, and the facility's collections procedures.

Second, each facility must identify on its website all insurers and HMOs for which the facility is in-network, or is a preferred provider, and post a link to each of them. The facility must notify patients, on its website, that services in the hospital may be provided by health care providers who may separately bill the patient.

Third, each facility must provide to patients and prospective patients, on request, a personalized, written estimate of the reasonably anticipated charges by the facility. The estimate must be provided within 3 days of request. The estimate may be based on the service bundles created by the APCD vendor, or, if the patient requests, must be based on the specific condition and characteristics of the patient. The estimate must clearly identify any facility fees, explain their purpose, and notify the patient that another facility or setting may have lower cost. If the patient requests it, the facility must notify the patient of any revisions to the estimate. Actual charges can vary from the estimate.

In issuing the estimate, the facility is not required to take the patient's insurance coverage into account, but must inform the patient that the patient may contact his or her insurer to get information about cost-sharing obligations. The estimate must also include notice of the facility's financial assistance policy. The facility must inform patients that they may request this personalized estimate, both from the facility and from the health care providers who provide care in the facility but bill the patient separately.

For a facility that fails to provide the estimate timely, the bill requires AHCA to fine the facility \$1,000 per day until the estimate is provided.

Finally, the bill requires facilities to post on their websites a weblink to the quality data available on the AHCA website [FloridaHealthFinder.gov](http://FloridaHealthFinder.gov), and to notify the public that the data is available.

## Health Care Practitioners

The bill requires health care practitioners to provide a written, good faith estimate of reasonably anticipated charges for nonemergency treatment of the patient's condition provided in a hospital or ASC within 3 days of a patient's request for the estimate. In issuing the estimate, the practitioner is not required to take the patient's insurance coverage into account, but must advise the patient that he or she may contact his or her insurer or HMO for more information on cost-sharing obligations related to the treatment. Actual charges can vary from the estimate.

These health care practitioners must also provide to uninsured patients, and insured patients for whom the practitioner is out-of-network, information on the practitioner's financial assistance policy, including the application process, payment plans discounts and collection procedures. Failure to

provide the estimate within 3 business days shall result in disciplinary action against the HCP under his or her practice act and a daily fine of \$500, capped at \$5,000.

### Insurers and HMOs

The bill requires each health insurer and HMO to make available on its website a method that consumers can use to estimate copayments, deductibles, and other cost-sharing requirements for health care services and procedures. The method to determine the consumer's cost-sharing obligations must be based on the service bundles established by the APCD vendor. The insured must be able to create an estimate using the service bundles, a specific provider, or a comparison of providers, or any combination thereof. Estimates must be calculated using the insured's policy and known plan usage during coverage period, and based on in-network or out-of-network providers.

Insurers and HMOs must also establish, on their websites, a method for patients to obtain a personalized estimate of their cost-sharing obligations, using the personalized estimates received from a facility or in-facility health care practitioner.

Insurers and HMOs must include, in every policy issued and in prospective enrollee materials, a notice that these estimates are available.

The bill requires insurers and HMOs to post on their websites a weblink to the quality data available on the AHCA website FloridaHealthFinder.gov.

### Post-Treatment Transparency

#### *Hospitals and ASCs*

The bill amends current billing requirements in s. 395.301, F.S., to require hospitals and ASCs to meet additional standards for clear and comprehensible billing.

Following the patient's discharge, the bill requires the facility to provide an itemized bill or statement to the patient, upon request, within 7 days. The bill or statement must be in plain language. Services received and expenses incurred must be listed by date and by provider, enumerating items at a level of detail proscribed by AHCA. The bill or statement must clearly identify any facility fee and explain its purpose. . The itemized bill or statement must identify each item as "paid", "pending third-party payment", or "pending payment by the patient," and include the amount due. If an amount is due from the patient, the itemized bill or statement has to also provide the due date. Finally, the bill or statement must inform the patient or the patient's survivor or legal guardian to contact his or her insurer or HMO regarding the patient's cost-sharing obligation for the medical services and procedures. Any subsequent bills or statements must meet these requirements, and clearly identify any revisions.

Each bill or statement issued by a facility must notify the patient of any health care practitioners who will bill the patient separately.

The bill requires facilities to make available electronically, upon request of the patient, all records necessary for verifying the accuracy of the itemized bill or statement within 10 business days of the request. A facility must respond to patient questions about the itemized bill within 7 business days of receiving the question. Lastly, the facility must provide AHCA's contact information if the patient is not satisfied with the answers to his or her questions about the bill or statement.

### Florida Center for Health Information and Transparency

The bill renames the Florida Center for Health Information and Policy Analysis as the Florida Center for Health Information and Transparency. The bill streamlines the Florida Center's functions, eliminating unnecessary language, obsolete provisions and duties that are redundant to the activities of other

agencies. The bill specifically prohibits AHCA from establishing an all payers claim database without express authority to do so from the Legislature.

Under the bill, the Florida Center must identify available datasets, compile new data when specifically authorized, and promote the use of extant health-related data and statistics. The Florida Center must maintain the datasets existing before July 1, 2016, unless those datasets duplicate information that is readily available from other credible sources. The Florida Center may collect or compile data on:

- Licensed health professionals, including physician surveys conducted under ss. 458.3191 and 459.0081, F.S.;
- Health service inventories;
- Service utilization data for licensed health care facilities; and
- Specific health care quality initiatives when other extant data is not adequate to achieve the objectives of the initiative.

The bill revises data submission requirements that apply to facilities and health care practitioners. Specifically, the bill directs AHCA to require the submission of data to facilitate transparency in health care pricing data and quality measures. Also, data to be submitted by insurers may include payments to health care facilities and HCPs, as specified by rule. The bill further directs AHCA to consult with vendors, the State Consumer Health Information and Policy Advisory Council, and public and private users to determine the data to be collected and the use of the data. AHCA must monitor data collection procedures and test data quality to ensure the data is accurate, valid, reliable, and complete.

#### *Patient Safety Culture Surveys*

The bill requires AHCA to develop hospital and ASC patient safety culture surveys to measure aspects of patient safety culture, including frequency of adverse events, quality of handoffs and transitions, comfort in reporting a potential problem or error, the level of teamwork within hospital units and the facility as a whole, staff compliance with patient safety regulations and guidelines, staff's perception of facility support for patient safety, and staff's opinions on whether or not they would undergo a health care service or procedure at the facility. In designing the survey or surveys, AHCA must review and analyze nationally recognized patient safety culture survey products, including but not limited to the patient safety surveys developed by the federal Agency for Healthcare Research and Quality to develop the patient safety culture survey.

The bill requires facilities to annually conduct and submit the results of the AHCA-designed culture survey to the Florida Center, and authorizes AHCA to adopt rules to govern the survey and submission process. AHCA must include the survey results in the health care quality measures available to the public.

Finally, the bill also makes various conforming changes to reflect the provisions of the bill.

The bill provides an effective date of July 1, 2016.

#### **B. SECTION DIRECTORY:**

**Section 1:** Amends s. 395.301, F.S., relating to itemized patient bill; form and content prescribed by the agency; patient admission status notification.

**Section 2:** Amends s. 408.05, F.S., relating to Florida Center for Health Information and Policy Analysis.

**Section 3:** Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.

**Section 4:** Amends s. 408.810, F.S., relating to minimum licensure requirements.

**Section 5:** Amends s. 456.0575, F.S., relating to duty to notify patients.

- Section 5:** Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
- Section 6:** Creates s. 627.6385, F.S., relating to disclosures to policyholders; calculations of cost sharing.
- Section 7:** Amends s. 641.54, F.S., relating to information disclosure.
- Section 8:** Amends s. 409.967, F.S., relating to managed care plan accountability.
- Section 9:** Amends s. 110.123, F.S., relating to state group insurance program.
- Section 10:** Amends s. 20.42, F.S., relating to Agency for Health Care Administration.
- Section 11:** Amends s. 381.026, F.S., relating to Florida Patient's Bill of Rights and Responsibilities.
- Section 12:** Amends s. 395.602, F.S., relating to rural hospitals.
- Section 13:** Amends s. 395.6025, F.S., relating to rural hospital replacement facilities.
- Section 14:** Amends s. 400.991, F.S., license requirements; background screenings; prohibitions.
- Section 15:** Amends s. 408.07, F.S., relating to definitions.
- Section 16:** Amends s. 408.18, F.S., relating to Health Care Community Antitrust Guidance Act.
- Section 17:** Amends s. 408.8065, F.S., relating to additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics.
- Section 18:** Amends s. 408.820, F.S., relating to exemptions.
- Section 19:** Amends s. 465.0244, F.S., relating to information disclosure.
- Section 20:** Amends s. 627.6499, F.S., relating to reporting by insurers and third-party administrators.
- Section 21:** Provides an effective date of July 1, 2016.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

#### 1. Revenues:

AHCA may realize an increase in revenue by imposing fines on facilities for failing to timely provide an estimate to a patient or prospective patient. Similarly, the Department of Health may realize an increase in revenue by imposing fines on health care practitioners providing non-emergency services in a facility who do not timely provide the estimate to patients or prospective patients. The amount of fines that may be collected under the bill is indeterminate.

#### 2. Expenditures:

The bill directs AHCA to contract with a vendor that has already developed a health care claims database and currently operates the database with the functionality required by the bill. The cost for the database and associated data collection and storage activities is estimated to require \$600,000 in recurring funds and \$3,100,000 in nonrecurring funds from the Health Care Trust Fund.

The following deliverables are included in the cost estimates:

- **Claims Data Collection from Limited Payers:**
  - Includes the costs to "on-board" a limited number of payers in Year 1.
  - It is anticipated that customization may be needed for some payers' on-boarding, with less expensive standardized templates for other payers.
  - The estimate also includes data validation and quality assurance activities.
- **Data Collection-Annual Refresh:**
  - The contracted vendor will run an annual data refresh to incorporate the latest price information gathered from the medical claims data submitted by payers.
  - Includes data validation and quality assurance activities to ensure accurate and valid data is submitted.
- **Modifying Service Bundles-Provider Level Price Data:**
  - Includes the modification of existing service bundles to incorporate the robust medical claims data provided by Florida payers that allows a consumer to search for prices at the provider level.

- Website Development-Functionality Enhancements for Florida:
  - Includes programming to allow a consumer to search for Florida-specific information.
  - Includes development work to implement enhancements to the website to accomplish the required functionality in the bill.
  - Includes third party testing of the site and program management.
- Data Storage:
  - Storage of the Florida-specific data for research purposes, as required in the bill.
- Research Request and Cost Recovery Planning:
  - One-time cost for setting the criteria, terms, and cost recoupment fees for access to the Florida-specific data set by researchers.

The cost to implement the patient safety culture survey, including the cost of a contracted research organization to collect, analyze, and report survey findings is estimated to be \$300,000 in recurring funds from the Health Care Trust Fund. AHCA intends to encourage online survey completion, which may reduce this estimate.<sup>128</sup> Additionally, the cost of one full-time equivalent (FTE) staff to manage the contract and survey process is estimated to be \$52,919 in recurring costs from the Health Care Trust Fund, with associated salary rate of 41,106.

Deliverable	YEAR 1		YEAR 2	
	Recurring	Non-Recurring	Recurring	Non-Recurring
Claims Data Collection from Limited Payers	-	\$1,250,000	-	-
Data Collection - Annual Refresh	\$450,000	-	\$450,000	-
Modifying Service Bundles-Provider Level Price Data	-	\$800,000	-	-
Website Development-Functionality Enhancements for Florida	-	\$1,000,000	-	-
Data Storage	\$150,000	-	\$150,000	-
Research Request and Cost Recovery Planning	-	\$50,000	-	-
<b>SubTotal</b>	<b>\$600,000</b>	<b>\$3,100,000</b>	<b>\$600,000</b>	<b>-</b>
Patient Safety Culture Survey	\$300,000	-	\$300,000	-
One Full Time Equivalent (FTE) Position - Pay Grade 24	\$52,919	-	\$52,919	-
<b>SubTotal</b>	<b>\$352,919</b>	<b>-</b>	<b>\$352,919</b>	<b>-</b>
<b>TOTAL</b>	<b>\$952,919</b>	<b>\$3,100,000</b>	<b>\$952,919</b>	<b>-</b>

<sup>128</sup> Email correspondence between AHCA staff and Select Committee staff on January 18, 2016 (on file with Select Committee staff).

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

1. Revenues:

None.

2. Expenditures:

None.

**C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

Hospitals and ASCs may incur costs associated with posting the required information on their websites, providing pre-treatment written, good faith estimates to patients and including more detailed information on itemized bills or statements provided to patients within 7 days of discharge from the facility.

Insurers and health maintenance organizations may incur costs associated with compiling and sending data to the vendor selected by AHCA to maintain the Florida-specific dataset accessible by the public and any interested party.

Consumers will have estimates of charges for health care, prior to receiving such care, and can plan financially for those costs. Also, the estimates will be clear and transparent, allowing a consumer to question charges and empowering him or her to negotiate prices.

Consumers will have access to a database that provides the average cost of health care service bundles for procedures or treatments. Such a tool will also empower a consumer to plan for health care and negotiate prices for medical services and treatment.

**D. FISCAL COMMENTS:**

None.

**III. COMMENTS**

**A. CONSTITUTIONAL ISSUES:**

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

**B. RULE-MAKING AUTHORITY:**

The bill provides sufficient rule-making authority to AHCA to implement the provisions of the bill.

**C. DRAFTING ISSUES OR OTHER COMMENTS:**

The bill exempts mobile surgical facilities from the provisions of the bill related to facility price transparency and itemized patient statement or bill, patient safety culture surveys, and facility requirements to post a link to the data disseminated by AHCA. According to AHCA, there are no mobile surgical facilities licensed in the state.

#### **IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

1                                   A bill to be entitled  
 2           An act relating to transparency in health care;  
 3           amending s. 395.301, F.S.; requiring a facility  
 4           licensed under chapter 395, F.S., to provide timely  
 5           and accurate financial information and quality of  
 6           service measures to certain individuals; requiring a  
 7           licensed facility to post certain payment information  
 8           regarding defined bundles of services and procedures  
 9           and other specified consumer information and  
 10          notifications on its website; requiring a facility to  
 11          provide a written, good faith estimate of charges to a  
 12          patient or prospective patient within a certain  
 13          timeframe; requiring a facility to provide information  
 14          regarding its financial assistance policy to a patient  
 15          or a prospective patient; providing a penalty for  
 16          failing to provide such estimate of charges to a  
 17          patient; deleting a requirement that a licensed  
 18          facility not operated by the state provide notice to a  
 19          patient of his or her right to an itemized bill within  
 20          a certain timeframe; revising the information that  
 21          must be included on a patient's statement or bill;  
 22          amending s. 408.05, F.S.; renaming the Florida Center  
 23          for Health Information and Policy Analysis; revising  
 24          requirements for the collection and use of health-  
 25          related data by the Agency for Health Care  
 26          Administration; requiring the agency to contract with

27 | a vendor to provide an Internet-based platform with  
 28 | certain attributes and a state-specific data set  
 29 | available to the public; providing vendor  
 30 | qualifications; requiring the agency to design a  
 31 | patient safety culture survey for hospitals and  
 32 | ambulatory surgical centers licensed under chapter  
 33 | 395, F.S.; requiring the survey to measure certain  
 34 | aspects of a facility's patient safety practices;  
 35 | exempting certain licensed facilities from survey  
 36 | requirements; prohibiting the agency from establishing  
 37 | a certain database without express legislative  
 38 | authority; revising the duties of the members of the  
 39 | State Consumer Health Information and Policy Advisory  
 40 | Council; deleting an obsolete provision; amending s.  
 41 | 408.061, F.S.; revising requirements for the  
 42 | submission of health care data to the agency; amending  
 43 | s. 408.810, F.S.; requiring certain licensed hospitals  
 44 | and ambulatory surgical centers to submit a facility  
 45 | patient safety culture survey to the agency; amending  
 46 | s. 456.0575, F.S.; requiring a health care  
 47 | practitioner to provide a good faith estimate of  
 48 | anticipated charges to a patient upon request within a  
 49 | certain timeframe; providing for disciplinary action  
 50 | and a fine for failure to comply; creating s.  
 51 | 627.6385, F.S.; requiring a health insurer to make  
 52 | available on its website certain information and a

53 method for policyholders to estimate certain health  
 54 care services costs and charges; providing that an  
 55 estimate does not preclude an actual cost from  
 56 exceeding the estimate; requiring a health insurer to  
 57 provide notice in insurance policies that certain  
 58 information is available on its website; requiring a  
 59 health insurer that participates in the state group  
 60 health insurance plan or Medicaid managed care to  
 61 contribute all Florida claims data to the contracted  
 62 vendor selected by the agency; amending s. 641.54,  
 63 F.S.; requiring a health maintenance organization to  
 64 make certain information available to its subscribers  
 65 on its website; requiring a health insurer to provide  
 66 a hyperlink to certain health information on its  
 67 website; requiring a health maintenance organization  
 68 that participates in the state group health insurance  
 69 plan or Medicaid managed care to contribute all  
 70 Florida claims data to the contracted vendor selected  
 71 by the agency; amending s. 409.967, F.S.; requiring  
 72 managed care plans to contribute all Florida claims  
 73 data to the contracted vendor selected by the agency;  
 74 amending s. 110.123, F.S.; requiring the Department of  
 75 Management Services to contribute certain data to the  
 76 vendor for the price transparency database established  
 77 by the agency; requiring a contracted vendor for the  
 78 state group health insurance plan to contribute

79 Florida claims data to the contracted vendor selected  
 80 by the agency; amending ss. 20.42, 381.026, 395.602,  
 81 395.6025, 400.991, 408.07, 408.18, 408.8065, 408.820,  
 82 465.0244, and 627.6499, F.S.; conforming cross-  
 83 references and provisions to changes made by the act;  
 84 providing an effective date.

85

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

87

88 Section 1. Section 395.301, Florida Statutes, is amended  
 89 to read:

90 395.301 Price transparency; itemized patient statement or  
 91 bill; ~~form and content prescribed by the agency;~~ patient  
 92 admission status notification.-

93 (1) A facility licensed under this chapter shall provide  
 94 timely and accurate financial information and quality of service  
 95 measures to prospective and actual patients of the facility, or  
 96 to patients' survivors or legal guardians, as appropriate. Such  
 97 information shall be provided in accordance with this section  
 98 and rules adopted by the agency pursuant to this chapter and s.  
 99 408.05. Licensed facilities operating exclusively as state  
 100 mental health treatment facilities or as mobile surgical  
 101 facilities are exempt from this subsection.

102 (a) Each licensed facility shall make available to the  
 103 public on its website information on payments made to that  
 104 facility for defined bundles of services and procedures. The

105 payment data must be presented and searchable in accordance with  
 106 the system established by the agency and its vendor using the  
 107 descriptive service bundles developed under s. 408.05(3)(c). At  
 108 a minimum, the facility shall provide the estimated average  
 109 payment received from all payors, excluding Medicaid and  
 110 Medicare, for the descriptive service bundles available at that  
 111 facility and the estimated payment range for such bundles. Using  
 112 plain language comprehensible to an ordinary layperson, the  
 113 facility must disclose that the information on average payments  
 114 and the payment ranges is an estimate of costs that may be  
 115 incurred by the patient or prospective patient and that actual  
 116 costs will be based on the services actually provided to the  
 117 patient. The facility shall also assist the consumer in  
 118 accessing his or her health insurer's or health maintenance  
 119 organization's website for information on estimated copayments,  
 120 deductibles, and other cost-sharing responsibilities. The  
 121 facility's website must:

122 1. Identify and post the names and hyperlinks for direct  
 123 access to the websites of all health insurers and health  
 124 maintenance organizations for which the facility is a network  
 125 provider or preferred provider.

126 2. Provide information to uninsured patients and insured  
 127 patients whose health insurer or health maintenance organization  
 128 does not include the facility as a network provider or preferred  
 129 provider on the facility's financial assistance policy,  
 130 including the application process, payment plans, and discounts

131 | and the facility's charity care policy and collection  
 132 | procedures.

133 | 3. Notify patients and prospective patients that services  
 134 | may be provided in the health care facility by the facility as  
 135 | well as by other health care practitioners who may separately  
 136 | bill the patient.

137 | 4. Inform patients and prospective patients that they may  
 138 | request from the facility and other health care practitioners a  
 139 | more personalized estimate of charges and other information.

140 | (b)1. Upon request, and before providing any nonemergency  
 141 | medical services, each licensed facility shall provide a  
 142 | written, good faith estimate of reasonably anticipated charges  
 143 | by the facility for the treatment of the patient's or  
 144 | prospective patient's specific condition. The facility must  
 145 | provide the estimate in writing to the patient or prospective  
 146 | patient within 3 business days after receipt of the request and  
 147 | is not required to adjust the estimate for any potential  
 148 | insurance coverage. The estimate may be based on the descriptive  
 149 | service bundles developed by the agency under s. 408.05(3)(c)  
 150 | unless the patient or prospective patient requests a more  
 151 | personalized and specific estimate that accounts for the  
 152 | specific condition and characteristics of the patient or  
 153 | prospective patient. The facility shall inform the patient or  
 154 | prospective patient that he or she may contact his or her health  
 155 | insurer or health maintenance organization for additional  
 156 | information concerning cost-sharing responsibilities.

157           2. In the estimate, the facility shall provide to the  
 158 patient or prospective patient information on the facility's  
 159 financial assistance policy, including the application process,  
 160 payment plans, and discounts and the facility's charity care  
 161 policy and collection procedures.

162           3. The estimate shall clearly identify any facility fees  
 163 and, if applicable, include a statement notifying the patient or  
 164 prospective patient that a facility fee is included in the  
 165 estimate, the purpose of the fee, and that the patient may pay  
 166 less for the procedure or service at another facility or in  
 167 another health care setting.

168           4. Upon request, the facility shall notify the patient or  
 169 prospective patient of any revision to the estimate.

170           5. In the estimate, the facility must notify the patient  
 171 or prospective patient that services may be provided in the  
 172 health care facility by the facility as well as by other health  
 173 care practitioners who may separately bill the patient.

174           6. The facility shall take action to educate the public  
 175 that such estimates are available upon request.

176           7. Failure to timely provide the estimate pursuant to this  
 177 paragraph shall result in a daily fine of \$1,000 until the  
 178 estimate is provided to the patient or prospective patient.

179  
 180 The provision of an estimate does not preclude the actual  
 181 charges from exceeding the estimate.

182           (c) Each facility shall make available on its website a

183 | hyperlink to the health-related data, including quality measures  
 184 | and statistics, that are disseminated by the agency pursuant to  
 185 | s. 408.05. The facility shall also take action to notify the  
 186 | public that such information is electronically available and  
 187 | provide a hyperlink to the agency's website.

188 | (d)1. Upon request, and after the patient's discharge or  
 189 | release from a facility, the facility must provide ~~A licensed~~  
 190 | ~~facility not operated by the state shall notify each patient~~  
 191 | ~~during admission and at discharge of his or her right to receive~~  
 192 | ~~an itemized bill upon request. Within 7 days following the~~  
 193 | ~~patient's discharge or release from a licensed facility not~~  
 194 | ~~operated by the state, the licensed facility providing the~~  
 195 | ~~service shall, upon request, submit to the patient, or to the~~  
 196 | ~~patient's survivor or legal guardian, as may be appropriate, an~~  
 197 | ~~itemized statement or bill detailing in plain language~~  
 198 | ~~comprehensible to an ordinary layperson the specific nature of~~  
 199 | ~~charges or expenses incurred by the patient., which in~~ The  
 200 | ~~initial~~ statement or bill ~~billing~~ shall be provided within 7  
 201 | days after the patient's discharge or release. The initial  
 202 | statement or bill must contain a statement of specific services  
 203 | received and expenses incurred by date and provider for such  
 204 | items of service, enumerating in detail as prescribed by the  
 205 | agency the constituent components of the services received  
 206 | within each department of the licensed facility and including  
 207 | unit price data on rates charged by the licensed facility, ~~as~~  
 208 | prescribed by the agency. The statement or bill must also

209 clearly identify any facility fee and explain the purpose of the  
 210 fee. The statement or bill must identify each item as paid,  
 211 pending payment by a third party, or pending payment by the  
 212 patient and must include the amount due, if applicable. If an  
 213 amount is due from the patient, a due date must be included. The  
 214 initial statement or bill must direct the patient or the  
 215 patient's survivor or legal guardian, as appropriate, to contact  
 216 the patient's insurer or health maintenance organization  
 217 regarding the patient's cost-sharing responsibilities.

218 2. Any subsequent statement or bill provided to a patient  
 219 or to the patient's survivor or legal guardian, as appropriate,  
 220 relating to the episode of care must include all of the  
 221 information required by subparagraph 1., with any revisions  
 222 clearly delineated.

223 (e)(2)(a) Each such statement or bill provided submitted  
 224 pursuant to this subsection section:

225 1. Must ~~May not~~ include notice charges of hospital-based  
 226 physicians and other health care practitioners who bill ~~if~~  
 227 ~~billed~~ separately.

228 2. May not include any generalized category of expenses  
 229 such as "other" or "miscellaneous" or similar categories.

230 3. Must ~~shall~~ list drugs by brand or generic name and not  
 231 refer to drug code numbers when referring to drugs of any sort.

232 4. Must ~~shall~~ specifically identify physical,  
 233 occupational, or speech therapy treatment by ~~as to the~~ date,  
 234 type, and length of treatment when such ~~therapy~~ treatment is a

235 part of the statement or bill.

236 ~~(b) Any person receiving a statement pursuant to this~~  
 237 ~~section shall be fully and accurately informed as to each charge~~  
 238 ~~and service provided by the institution preparing the statement.~~

239 ~~(2)~~(3) On each itemized statement or bill submitted  
 240 pursuant to subsection (1), there shall appear the words "A FOR-  
 241 PROFIT (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY  
 242 SURGICAL CENTER) LICENSED BY THE STATE OF FLORIDA" or  
 243 substantially similar words sufficient to identify clearly and  
 244 plainly the ownership status of the licensed facility. Each  
 245 itemized statement or bill must prominently display the  
 246 telephone ~~phone~~ number of the medical facility's patient liaison  
 247 who is responsible for expediting the resolution of any billing  
 248 dispute between the patient, or the patient's survivor or legal  
 249 guardian ~~his or her representative~~, and the billing department.

250 ~~(4) An itemized bill shall be provided once to the~~  
 251 ~~patient's physician at the physician's request, at no charge.~~

252 ~~(5) In any billing for services subsequent to the initial~~  
 253 ~~billing for such services, the patient, or the patient's~~  
 254 ~~survivor or legal guardian, may elect, at his or her option, to~~  
 255 ~~receive a copy of the detailed statement of specific services~~  
 256 ~~received and expenses incurred for each such item of service as~~  
 257 ~~provided in subsection (1).~~

258 ~~(6) No physician, dentist, podiatric physician, or~~  
 259 ~~licensed facility may add to the price charged by any third~~  
 260 ~~party except for a service or handling charge representing a~~

261 ~~cost actually incurred as an item of expense; however, the~~  
 262 ~~physician, dentist, podiatric physician, or licensed facility is~~  
 263 ~~entitled to fair compensation for all professional services~~  
 264 ~~rendered. The amount of the service or handling charge, if any,~~  
 265 ~~shall be set forth clearly in the bill to the patient.~~

266 ~~(7) Each licensed facility not operated by the state shall~~  
 267 ~~provide, prior to provision of any nonemergency medical~~  
 268 ~~services, a written good faith estimate of reasonably~~  
 269 ~~anticipated charges for the facility to treat the patient's~~  
 270 ~~condition upon written request of a prospective patient. The~~  
 271 ~~estimate shall be provided to the prospective patient within 7~~  
 272 ~~business days after the receipt of the request. The estimate may~~  
 273 ~~be the average charges for that diagnosis related group or the~~  
 274 ~~average charges for that procedure. Upon request, the facility~~  
 275 ~~shall notify the patient of any revision to the good faith~~  
 276 ~~estimate. Such estimate shall not preclude the actual charges~~  
 277 ~~from exceeding the estimate. The facility shall place a notice~~  
 278 ~~in the reception area that such information is available.~~  
 279 ~~Failure to provide the estimate within the provisions~~  
 280 ~~established pursuant to this section shall result in a fine of~~  
 281 ~~\$500 for each instance of the facility's failure to provide the~~  
 282 ~~requested information.~~

283 ~~(8) Each licensed facility that is not operated by the~~  
 284 ~~state shall provide any uninsured person seeking planned~~  
 285 ~~nonemergency elective admission a written good faith estimate of~~  
 286 ~~reasonably anticipated charges for the facility to treat such~~

287 ~~person. The estimate must be provided to the uninsured person~~  
 288 ~~within 7 business days after the person notifies the facility~~  
 289 ~~and the facility confirms that the person is uninsured. The~~  
 290 ~~estimate may be the average charges for that diagnosis-related~~  
 291 ~~group or the average charges for that procedure. Upon request,~~  
 292 ~~the facility shall notify the person of any revision to the good~~  
 293 ~~faith estimate. Such estimate does not preclude the actual~~  
 294 ~~charges from exceeding the estimate. The facility shall also~~  
 295 ~~provide to the uninsured person a copy of any facility discount~~  
 296 ~~and charity care discount policies for which the uninsured~~  
 297 ~~person may be eligible. The facility shall place a notice in the~~  
 298 ~~reception area where such information is available. Failure to~~  
 299 ~~provide the estimate as required by this subsection shall result~~  
 300 ~~in a fine of \$500 for each instance of the facility's failure to~~  
 301 ~~provide the requested information.~~

302 ~~(3)(9)~~ If a licensed facility places a patient on  
 303 observation status rather than inpatient status, observation  
 304 services shall be documented in the patient's discharge papers.  
 305 The patient or the patient's survivor or legal guardian ~~proxy~~  
 306 shall be notified of observation services through discharge  
 307 papers, which may also include brochures, signage, or other  
 308 forms of communication for this purpose.

309 ~~(4)(10)~~ A licensed facility shall make available to a  
 310 patient all records necessary for verification of the accuracy  
 311 of the patient's statement or bill within 10 ~~30~~ business days  
 312 after the request for such records. The records ~~verification~~

313 ~~information~~ must be made available in the facility's offices and  
 314 through electronic means that comply with the Health Insurance  
 315 Portability and Accountability Act of 1996 (HIPAA). Such records  
 316 must ~~shall~~ be available to the patient before ~~prior to~~ and after  
 317 payment of the statement or bill ~~or claim~~. The facility may not  
 318 charge the patient for making such ~~verification~~ records  
 319 available; however, the facility may charge its usual fee for  
 320 providing copies of records as specified in s. 395.3025.

321 (5) ~~(11)~~ Each facility shall establish a method for  
 322 reviewing and responding to questions from patients concerning  
 323 the patient's itemized statement or bill. Such response shall be  
 324 provided within 7 business ~~30~~ days after the date a question is  
 325 received. If the patient is not satisfied with the response, the  
 326 facility must provide the patient with the contact information  
 327 for ~~address of~~ the agency to which the issue may be sent for  
 328 review.

329 ~~(12)~~ Each licensed facility shall make available on its  
 330 Internet website a link to the performance outcome and financial  
 331 data that is published by the Agency for Health Care  
 332 Administration pursuant to s. 408.05(3)(k). The facility shall  
 333 place a notice in the reception area that the information is  
 334 available electronically and the facility's Internet website  
 335 address.

336 Section 2. Section 408.05, Florida Statutes, is amended to  
 337 read:

338 408.05 Florida Center for Health Information and

339 Transparency Policy Analysis.—

340 (1) ESTABLISHMENT.—The agency shall establish and maintain  
 341 a Florida Center for Health Information and Transparency to  
 342 collect, compile, coordinate, analyze, index, and disseminate  
 343 Policy Analysis. ~~The center shall establish a comprehensive~~  
 344 ~~health information system to provide for the collection,~~  
 345 ~~compilation, coordination, analysis, indexing, dissemination,~~  
 346 ~~and utilization of both purposefully collected and extant~~  
 347 health-related data and statistics. The center shall be staffed  
 348 as with public health experts, biostatisticians, information  
 349 system analysts, health policy experts, economists, and other  
 350 staff necessary to carry out its functions.

351 (2) HEALTH-RELATED DATA.—The ~~comprehensive health~~  
 352 ~~information system operated by the Florida Center for Health~~  
 353 Information and Transparency Policy Analysis shall identify ~~the~~  
 354 ~~best~~ available data sets, compile new data when specifically  
 355 authorized, sources and promote the use ~~coordinate the~~  
 356 ~~compilation~~ of extant health-related data and statistics. The  
 357 center must maintain any data sets in existence before July 1,  
 358 2016, unless such data sets duplicate information that is  
 359 readily available from other credible sources, and may ~~and~~  
 360 purposefully collect or compile data on:

361 (a) ~~The extent and nature of illness and disability of the~~  
 362 ~~state population, including life expectancy, the incidence of~~  
 363 ~~various acute and chronic illnesses, and infant and maternal~~  
 364 ~~morbidity and mortality.~~

365 ~~(b) The impact of illness and disability of the state~~  
 366 ~~population on the state economy and on other aspects of the~~  
 367 ~~well being of the people in this state.~~

368 ~~(c) Environmental, social, and other health hazards.~~

369 ~~(d) Health knowledge and practices of the people in this~~  
 370 ~~state and determinants of health and nutritional practices and~~  
 371 ~~status.~~

372 (a)~~(e)~~ Health resources, including licensed physicians,  
 373 dentists, nurses, and other health care practitioners  
 374 professionals, by specialty and type of practice. Such data  
 375 shall include information collected by the Department of Health  
 376 pursuant to ss. 458.3191 and 459.0081.

377 (b) Health service inventories, including ~~and~~ acute care,  
 378 long-term care, and other institutional care facilities ~~facility~~  
 379 ~~supplies~~ and specific services provided by hospitals, nursing  
 380 homes, home health agencies, and other licensed health care  
 381 facilities.

382 (c)~~(f)~~ Service utilization for licensed ~~of~~ health care  
 383 facilities by type of provider.

384 (d)~~(g)~~ Health care costs and financing, including trends  
 385 in health care prices and costs, the sources of payment for  
 386 health care services, and federal, state, and local expenditures  
 387 for health care.

388 ~~(h) Family formation, growth, and dissolution.~~

389 (e)~~(i)~~ The extent of public and private health insurance  
 390 coverage in this state.

391 (f)(j) Specific quality-of-care initiatives involving The  
 392 ~~quality of care provided by~~ various health care providers when  
 393 extant data is not adequate to achieve the objectives of the  
 394 initiative.

395 (3) ~~COMPREHENSIVE HEALTH INFORMATION TRANSPARENCY SYSTEM.~~--  
 396 In order to disseminate and facilitate the availability of  
 397 ~~produce~~ comparable and uniform health information ~~and statistics~~  
 398 ~~for the development of policy recommendations,~~ the agency shall  
 399 ~~perform the following functions:~~

400 (a) Collect and compile information on and coordinate the  
 401 activities of state agencies involved in providing the design  
 402 ~~and implementation of the comprehensive health information to~~  
 403 consumers system.

404 (b) Promote data sharing through dissemination of state-  
 405 collected health data by making such data available,  
 406 transferable, and readily usable ~~Undertake research,~~  
 407 ~~development, and evaluation respecting the comprehensive health~~  
 408 ~~information system.~~

409 (c) Contract with a vendor to provide a consumer-friendly,  
 410 Internet-based platform that allows a consumer to research the  
 411 cost of health care services and procedures and allows for price  
 412 comparison. The Internet-based platform must allow a consumer to  
 413 search by condition or service bundles that are comprehensible  
 414 to an ordinary layperson and may not require registration, a  
 415 security password, or user identification. The vendor shall also  
 416 establish and maintain a Florida-specific data set of health

417 | care claims information available to the public and any  
 418 | interested party. The vendor must be a nonprofit research  
 419 | institute that is qualified under s. 1874 of the Social Security  
 420 | Act to receive Medicare claims data and that receives claims  
 421 | data from multiple private insurers nationwide. The vendor must  
 422 | have:

423 |       1. A national database consisting of at least 15 billion  
 424 | claim lines of administrative claims data from multiple payors  
 425 | capable of being expanded by adding third-party payors,  
 426 | including employers with health plans covered by the Employee  
 427 | Retirement Income Security Act of 1974 (ERISA).

428 |       2. A well-developed methodology for analyzing claims data  
 429 | within defined service bundles.

430 |       3. A bundling methodology that is available in the public  
 431 | domain to allow for consistency and comparison of state and  
 432 | national benchmarks with local regions and specific providers.

433 |       (d) Design a patient safety culture survey or surveys to  
 434 | be completed annually by each hospital and ambulatory surgical  
 435 | center licensed under chapter 395. The survey or surveys shall  
 436 | be anonymous to encourage staff employed by or working in the  
 437 | facility to complete the survey. The survey or surveys shall be  
 438 | designed to measure aspects of patient safety culture, including  
 439 | frequency of adverse events, quality of handoffs and  
 440 | transitions, comfort in reporting a potential problem or error,  
 441 | the level of teamwork within hospital units and the facility as  
 442 | a whole, staff compliance with patient safety regulations and

443 guidelines, staff perception of facility support for patient  
 444 safety, and staff opinions on whether they would undergo a  
 445 health care service or procedure at the facility. The agency  
 446 shall review and analyze nationally recognized patient safety  
 447 culture survey products, including, but not limited to, the  
 448 patient safety surveys developed by the federal Agency for  
 449 Healthcare Research and Quality, to develop the patient safety  
 450 culture survey. This paragraph does not apply to licensed  
 451 facilities operating exclusively as state mental health  
 452 treatment facilities or as mobile surgical facilities.

453 ~~(e) Review the statistical activities of state agencies to~~  
 454 ~~ensure that they are consistent with the comprehensive health~~  
 455 ~~information system.~~

456 ~~(e)(d) Develop written agreements with local, state, and~~  
 457 ~~federal agencies to facilitate for the sharing of data related~~  
 458 ~~to health care health care-related data or using the facilities~~  
 459 ~~and services of such agencies. State agencies, local health~~  
 460 ~~councils, and other agencies under state contract shall assist~~  
 461 ~~the center in obtaining, compiling, and transferring health-~~  
 462 ~~care-related data maintained by state and local agencies.~~  
 463 ~~Written agreements must specify the types, methods, and~~  
 464 ~~periodicity of data exchanges and specify the types of data that~~  
 465 ~~will be transferred to the center.~~

466 ~~(f)(e) Establish by rule the types of data collected,~~  
 467 ~~compiled, processed, used, or shared. Decisions regarding center~~  
 468 ~~data sets should be made based on consultation with the State~~

469 ~~Consumer Health Information and Policy Advisory Council and~~  
 470 ~~other public and private users regarding the types of data which~~  
 471 ~~should be collected and their uses. The center shall establish~~  
 472 ~~standardized means for collecting health information and~~  
 473 ~~statistics under laws and rules administered by the agency.~~

474 (g) Consult with contracted vendors, the State Consumer  
 475 Health Information and Policy Advisory Council, and other public  
 476 and private users regarding the types of data that should be  
 477 collected and the use of such data.

478 (h) Monitor data collection procedures and test data  
 479 quality to facilitate the dissemination of data that is  
 480 accurate, valid, reliable, and complete.

481 ~~(f) Establish minimum health care related data sets which~~  
 482 ~~are necessary on a continuing basis to fulfill the collection~~  
 483 ~~requirements of the center and which shall be used by state~~  
 484 ~~agencies in collecting and compiling health care related data.~~  
 485 ~~The agency shall periodically review ongoing health care data~~  
 486 ~~collections of the Department of Health and other state agencies~~  
 487 ~~to determine if the collections are being conducted in~~  
 488 ~~accordance with the established minimum sets of data.~~

489 ~~(g) Establish advisory standards to ensure the quality of~~  
 490 ~~health statistical and epidemiological data collection,~~  
 491 ~~processing, and analysis by local, state, and private~~  
 492 ~~organizations.~~

493 ~~(h) Prescribe standards for the publication of health-~~  
 494 ~~care related data reported pursuant to this section which ensure~~

495 ~~the reporting of accurate, valid, reliable, complete, and~~  
 496 ~~comparable data. Such standards should include advisory warnings~~  
 497 ~~to users of the data regarding the status and quality of any~~  
 498 ~~data reported by or available from the center.~~

499 ~~(i) Develop Prescribe standards for the maintenance and~~  
 500 ~~preservation of the center's data. This should include methods~~  
 501 ~~for archiving data, retrieval of archived data, and data editing~~  
 502 ~~and verification.~~

503 ~~(j) Ensure that strict quality control measures are~~  
 504 ~~maintained for the dissemination of data through publications,~~  
 505 ~~studies, or user requests.~~

506 ~~(j)(k) Make Develop, in conjunction with the State~~  
 507 ~~Consumer Health Information and Policy Advisory Council, and~~  
 508 ~~implement a long-range plan for making available health care~~  
 509 ~~quality measures and financial data that will allow consumers to~~  
 510 ~~compare outcomes and other performance measures for health care~~  
 511 ~~services. The health care quality measures and financial data~~  
 512 ~~the agency must make available include, but are not limited to,~~  
 513 ~~pharmaceuticals, physicians, health care facilities, and health~~  
 514 ~~plans and managed care entities. The agency shall update the~~  
 515 ~~plan and report on the status of its implementation annually.~~  
 516 ~~The agency shall also make the plan and status report available~~  
 517 ~~to the public on its Internet website. As part of the plan, the~~  
 518 ~~agency shall identify the process and timeframes for~~  
 519 ~~implementation, barriers to implementation, and recommendations~~  
 520 ~~of changes in the law that may be enacted by the Legislature to~~

521 ~~eliminate the barriers. As preliminary elements of the plan, the~~  
 522 ~~agency shall:~~

523 ~~1. Make available patient safety indicators, inpatient~~  
 524 ~~quality indicators, and performance outcome and patient charge~~  
 525 ~~data collected from health care facilities pursuant to s.~~  
 526 ~~408.061(1)(a) and (2). The terms "patient safety indicators" and~~  
 527 ~~"inpatient quality indicators" have the same meaning as that~~  
 528 ~~ascribed by the Centers for Medicare and Medicaid Services, an~~  
 529 ~~accrediting organization whose standards incorporate comparable~~  
 530 ~~regulations required by this state, or a national entity that~~  
 531 ~~establishes standards to measure the performance of health care~~  
 532 ~~providers, or by other states. The agency shall determine which~~  
 533 ~~conditions, procedures, health care quality measures, and~~  
 534 ~~patient charge data to disclose based upon input from the~~  
 535 ~~council. When determining which conditions and procedures are to~~  
 536 ~~be disclosed, the council and the agency shall consider~~  
 537 ~~variation in costs, variation in outcomes, and magnitude of~~  
 538 ~~variations and other relevant information. When determining~~  
 539 ~~which health care quality measures to disclose, the agency:~~

540 ~~a. Shall consider such factors as volume of cases, average~~  
 541 ~~patient charges, average length of stay, complication rates,~~  
 542 ~~mortality rates, and infection rates, among others, which shall~~  
 543 ~~be adjusted for case mix and severity, if applicable.~~

544 ~~b. May consider such additional measures that are adopted~~  
 545 ~~by the Centers for Medicare and Medicaid Studies, an accrediting~~  
 546 ~~organization whose standards incorporate comparable regulations~~

547 ~~required by this state, the National Quality Forum, the Joint~~  
 548 ~~Commission on Accreditation of Healthcare Organizations, the~~  
 549 ~~Agency for Healthcare Research and Quality, the Centers for~~  
 550 ~~Disease Control and Prevention, or a similar national entity~~  
 551 ~~that establishes standards to measure the performance of health~~  
 552 ~~care providers, or by other states.~~

553  
 554 ~~When determining which patient charge data to disclose, the~~  
 555 ~~agency shall include such measures as the average of~~  
 556 ~~undiscounted charges on frequently performed procedures and~~  
 557 ~~preventive diagnostic procedures, the range of procedure charges~~  
 558 ~~from highest to lowest, average net revenue per adjusted patient~~  
 559 ~~day, average cost per adjusted patient day, and average cost per~~  
 560 ~~admission, among others.~~

561 ~~2. Make available performance measures, benefit design,~~  
 562 ~~and premium cost data from health plans licensed pursuant to~~  
 563 ~~chapter 627 or chapter 641. The agency shall determine which~~  
 564 ~~health care quality measures and member and subscriber cost data~~  
 565 ~~to disclose, based upon input from the council. When determining~~  
 566 ~~which data to disclose, the agency shall consider information~~  
 567 ~~that may be required by either individual or group purchasers to~~  
 568 ~~assess the value of the product, which may include membership~~  
 569 ~~satisfaction, quality of care, current enrollment or membership,~~  
 570 ~~coverage areas, accreditation status, premium costs, plan costs,~~  
 571 ~~premium increases, range of benefits, copayments and~~  
 572 ~~deductibles, accuracy and speed of claims payment, credentials~~

573 ~~of physicians, number of providers, names of network providers,~~  
 574 ~~and hospitals in the network. Health plans shall make available~~  
 575 ~~to the agency such data or information that is not currently~~  
 576 ~~reported to the agency or the office.~~

577 ~~3. Determine the method and format for public disclosure~~  
 578 ~~of data reported pursuant to this paragraph. The agency shall~~  
 579 ~~make its determination based upon input from the State Consumer~~  
 580 ~~Health Information and Policy Advisory Council. At a minimum,~~  
 581 ~~the data shall be made available on the agency's Internet~~  
 582 ~~website in a manner that allows consumers to conduct an~~  
 583 ~~interactive search that allows them to view and compare the~~  
 584 ~~information for specific providers. The website must include~~  
 585 ~~such additional information as is determined necessary to ensure~~  
 586 ~~that the website enhances informed decisionmaking among~~  
 587 ~~consumers and health care purchasers, which shall include, at a~~  
 588 ~~minimum, appropriate guidance on how to use the data and an~~  
 589 ~~explanation of why the data may vary from provider to provider.~~

590 ~~4. Publish on its website undiscounted charges for no~~  
 591 ~~fewer than 150 of the most commonly performed adult and~~  
 592 ~~pediatric procedures, including outpatient, inpatient,~~  
 593 ~~diagnostic, and preventative procedures.~~

594 ~~(4) TECHNICAL ASSISTANCE.—~~

595 ~~(a) The center shall provide technical assistance to~~  
 596 ~~persons or organizations engaged in health planning activities~~  
 597 ~~in the effective use of statistics collected and compiled by the~~  
 598 ~~center. The center shall also provide the following additional~~

599 ~~technical assistance services:~~

600 ~~1. Establish procedures identifying the circumstances~~  
 601 ~~under which, the places at which, the persons from whom, and the~~  
 602 ~~methods by which a person may secure data from the center,~~  
 603 ~~including procedures governing requests, the ordering of~~  
 604 ~~requests, timeframes for handling requests, and other procedures~~  
 605 ~~necessary to facilitate the use of the center's data. To the~~  
 606 ~~extent possible, the center should provide current data timely~~  
 607 ~~in response to requests from public or private agencies.~~

608 ~~2. Provide assistance to data sources and users in the~~  
 609 ~~areas of database design, survey design, sampling procedures,~~  
 610 ~~statistical interpretation, and data access to promote improved~~  
 611 ~~health care related data sets.~~

612 ~~3. Identify health care data gaps and provide technical~~  
 613 ~~assistance to other public or private organizations for meeting~~  
 614 ~~documented health care data needs.~~

615 ~~4. Assist other organizations in developing statistical~~  
 616 ~~abstracts of their data sets that could be used by the center.~~

617 ~~5. Provide statistical support to state agencies with~~  
 618 ~~regard to the use of databases maintained by the center.~~

619 ~~6. To the extent possible, respond to multiple requests~~  
 620 ~~for information not currently collected by the center or~~  
 621 ~~available from other sources by initiating data collection.~~

622 ~~7. Maintain detailed information on data maintained by~~  
 623 ~~other local, state, federal, and private agencies in order to~~  
 624 ~~advise those who use the center of potential sources of data~~

625 ~~which are requested but which are not available from the center.~~

626 ~~8. Respond to requests for data which are not available in~~  
 627 ~~published form by initiating special computer runs on data sets~~  
 628 ~~available to the center.~~

629 ~~9. Monitor innovations in health information technology,~~  
 630 ~~informatics, and the exchange of health information and maintain~~  
 631 ~~a repository of technical resources to support the development~~  
 632 ~~of a health information network.~~

633 ~~(b) The agency shall administer, manage, and monitor~~  
 634 ~~grants to not for profit organizations, regional health~~  
 635 ~~information organizations, public health departments, or state~~  
 636 ~~agencies that submit proposals for planning, implementation, or~~  
 637 ~~training projects to advance the development of a health~~  
 638 ~~information network. Any grant contract shall be evaluated to~~  
 639 ~~ensure the effective outcome of the health information project.~~

640 ~~(c) The agency shall initiate, oversee, manage, and~~  
 641 ~~evaluate the integration of health care data from each state~~  
 642 ~~agency that collects, stores, and reports on health care issues~~  
 643 ~~and make that data available to any health care practitioner~~  
 644 ~~through a state health information network.~~

645 ~~(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES. The center~~  
 646 ~~shall provide for the widespread dissemination of data which it~~  
 647 ~~collects and analyzes. The center shall have the following~~  
 648 ~~publication, reporting, and special study functions:~~

649 ~~(a) The center shall publish and make available~~  
 650 ~~periodically to agencies and individuals health statistics~~

651 ~~publications of general interest, including health plan consumer~~  
 652 ~~reports and health maintenance organization member satisfaction~~  
 653 ~~surveys; publications providing health statistics on topical~~  
 654 ~~health policy issues; publications that provide health status~~  
 655 ~~profiles of the people in this state; and other topical health~~  
 656 ~~statistics publications.~~

657 ~~(k)(b) The center shall publish, Make available, and~~  
 658 ~~disseminate, promptly and as widely as practicable, the results~~  
 659 ~~of special health surveys, including facility patient safety~~  
 660 ~~culture surveys, health care research, and health care~~  
 661 ~~evaluations conducted or supported under this section. Any~~  
 662 ~~publication by the center must include a statement of the~~  
 663 ~~limitations on the quality, accuracy, and completeness of the~~  
 664 ~~data.~~

665 ~~(c) The center shall provide indexing, abstracting,~~  
 666 ~~translation, publication, and other services leading to a more~~  
 667 ~~effective and timely dissemination of health care statistics.~~

668 ~~(d) The center shall be responsible for publishing and~~  
 669 ~~disseminating an annual report on the center's activities.~~

670 ~~(e) The center shall be responsible, to the extent~~  
 671 ~~resources are available, for conducting a variety of special~~  
 672 ~~studies and surveys to expand the health care information and~~  
 673 ~~statistics available for health policy analyses, particularly~~  
 674 ~~for the review of public policy issues. The center shall develop~~  
 675 ~~a process by which users of the center's data are periodically~~  
 676 ~~surveyed regarding critical data needs and the results of the~~

677 ~~survey considered in determining which special surveys or~~  
 678 ~~studies will be conducted. The center shall select problems in~~  
 679 ~~health care for research, policy analyses, or special data~~  
 680 ~~collections on the basis of their local, regional, or state~~  
 681 ~~importance; the unique potential for definitive research on the~~  
 682 ~~problem; and opportunities for application of the study~~  
 683 ~~findings.~~

684 (4)~~(6)~~ PROVIDER DATA REPORTING.—This section does not  
 685 confer on the agency the power to demand or require that a  
 686 health care provider or professional furnish information,  
 687 records of interviews, written reports, statements, notes,  
 688 memoranda, or data other than as expressly required by law. The  
 689 agency may not establish an all-payor claims database or a  
 690 comparable database without express legislative authority.

691 (5)~~(7)~~ BUDGET; FEES.—

692 (a) The Legislature intends that funding for the Florida  
 693 Center for Health Information and Transparency Policy Analysis  
 694 be appropriated from the General Revenue Fund.

695 (b) The Florida Center for Health Information and  
 696 Transparency Policy Analysis may apply for and receive and  
 697 accept grants, gifts, and other payments, including property and  
 698 services, from any governmental or other public or private  
 699 entity or person and make arrangements as to the use of same,  
 700 including the undertaking of special studies and other projects  
 701 relating to health-care-related topics. Funds obtained pursuant  
 702 to this paragraph may not be used to offset annual

703 appropriations from the General Revenue Fund.

704 (c) The center may charge such reasonable fees for  
 705 services as the agency prescribes by rule. The established fees  
 706 may not exceed the reasonable cost for such services. Fees  
 707 collected may not be used to offset annual appropriations from  
 708 the General Revenue Fund.

709 (6)~~(8)~~ STATE CONSUMER HEALTH INFORMATION AND POLICY  
 710 ADVISORY COUNCIL.—

711 (a) There is established in the agency the State Consumer  
 712 Health Information and Policy Advisory Council to assist the  
 713 center ~~in reviewing the comprehensive health information system,~~  
 714 ~~including the identification, collection, standardization,~~  
 715 ~~sharing, and coordination of health related data, fraud and~~  
 716 ~~abuse data, and professional and facility licensing data among~~  
 717 ~~federal, state, local, and private entities and to recommend~~  
 718 ~~improvements for purposes of public health, policy analysis, and~~  
 719 ~~transparency of consumer health care information.~~ The council  
 720 shall consist of the following members:

721 1. An employee of the Executive Office of the Governor, to  
 722 be appointed by the Governor.

723 2. An employee of the Office of Insurance Regulation, to  
 724 be appointed by the director of the office.

725 3. An employee of the Department of Education, to be  
 726 appointed by the Commissioner of Education.

727 4. Ten persons, to be appointed by the Secretary of Health  
 728 Care Administration, representing other state and local

729 agencies, state universities, business and health coalitions,  
 730 local health councils, professional health-care-related  
 731 associations, consumers, and purchasers.

732 (b) Each member of the council shall be appointed to serve  
 733 for a term of 2 years following the date of appointment, ~~except~~  
 734 ~~the term of appointment shall end 3 years following the date of~~  
 735 ~~appointment for members appointed in 2003, 2004, and 2005.~~ A  
 736 vacancy shall be filled by appointment for the remainder of the  
 737 term, and each appointing authority retains the right to  
 738 reappoint members whose terms of appointment have expired.

739 (c) The council may meet at the call of its chair, at the  
 740 request of the agency, or at the request of a majority of its  
 741 membership, but the council must meet at least quarterly.

742 (d) Members shall elect a chair and vice chair annually.

743 (e) A majority of the members constitutes a quorum, and  
 744 the affirmative vote of a majority of a quorum is necessary to  
 745 take action.

746 (f) The council shall maintain minutes of each meeting and  
 747 shall make such minutes available to any person.

748 (g) Members of the council shall serve without  
 749 compensation but shall be entitled to receive reimbursement for  
 750 per diem and travel expenses as provided in s. 112.061.

751 (h) The council's duties and responsibilities include, but  
 752 are not limited to, the following:

753 1. To develop a mission statement, goals, and a plan of  
 754 action for the identification, collection, standardization,

755 | sharing, and coordination of health-related data across federal,  
 756 | state, and local government and private sector entities.

757 |       2. To develop a review process to ensure cooperative  
 758 | planning among agencies that collect or maintain health-related  
 759 | data.

760 |       3. To create ad hoc issue-oriented technical workgroups on  
 761 | an as-needed basis to make recommendations to the council.

762 |       ~~(7)-(9)~~ APPLICATION TO OTHER AGENCIES. ~~Nothing in~~ This  
 763 | section does not shall limit, restrict, affect, or control the  
 764 | collection, analysis, release, or publication of data by any  
 765 | state agency pursuant to its statutory authority, duties, or  
 766 | responsibilities.

767 |       Section 3. Subsection (1) of section 408.061, Florida  
 768 | Statutes, is amended to read:

769 |       408.061 Data collection; uniform systems of financial  
 770 | reporting; information relating to physician charges;  
 771 | confidential information; immunity.-

772 |       (1) The agency shall require the submission by health care  
 773 | facilities, health care providers, and health insurers of data  
 774 | necessary to carry out the agency's duties and to facilitate  
 775 | transparency in health care pricing data and quality measures.

776 | Specifications for data to be collected under this section shall  
 777 | be developed by the agency and applicable contract vendors, with  
 778 | the assistance of technical advisory panels including  
 779 | representatives of affected entities, consumers, purchasers, and  
 780 | such other interested parties as may be determined by the

781 agency.

782 (a) Data submitted by health care facilities, including

783 the facilities as defined in chapter 395, shall include, but are

784 not limited to: case-mix data, patient admission and discharge

785 data, hospital emergency department data which shall include the

786 number of patients treated in the emergency department of a

787 licensed hospital reported by patient acuity level, data on

788 hospital-acquired infections as specified by rule, data on

789 complications as specified by rule, data on readmissions as

790 specified by rule, with patient and provider-specific

791 identifiers included, actual charge data by diagnostic groups or

792 other bundled groupings as specified by rule, facility patient

793 safety culture surveys, financial data, accounting data,

794 operating expenses, expenses incurred for rendering services to

795 patients who cannot or do not pay, interest charges,

796 depreciation expenses based on the expected useful life of the

797 property and equipment involved, and demographic data. The

798 agency shall adopt nationally recognized risk adjustment

799 methodologies or software consistent with the standards of the

800 Agency for Healthcare Research and Quality and as selected by

801 the agency for all data submitted as required by this section.

802 Data may be obtained from documents such as, but not limited to:

803 leases, contracts, debt instruments, itemized patient statements

804 or bills, medical record abstracts, and related diagnostic

805 information. Reported data elements shall be reported

806 electronically in accordance with rule 59E-7.012, Florida

807 Administrative Code. Data submitted shall be certified by the  
 808 chief executive officer or an appropriate and duly authorized  
 809 representative or employee of the licensed facility that the  
 810 information submitted is true and accurate.

811 (b) Data to be submitted by health care providers may  
 812 include, but are not limited to: professional organization and  
 813 specialty board affiliations, Medicare and Medicaid  
 814 participation, types of services offered to patients, actual  
 815 charges to patients as specified by rule, amount of revenue and  
 816 expenses of the health care provider, and such other data which  
 817 are reasonably necessary to study utilization patterns. Data  
 818 submitted shall be certified by the appropriate duly authorized  
 819 representative or employee of the health care provider that the  
 820 information submitted is true and accurate.

821 (c) Data to be submitted by health insurers may include,  
 822 but are not limited to: claims, payments to health care  
 823 facilities and health care providers as specified by rule,  
 824 premium, administration, and financial information. Data  
 825 submitted shall be certified by the chief financial officer, an  
 826 appropriate and duly authorized representative, or an employee  
 827 of the insurer that the information submitted is true and  
 828 accurate.

829 (d) Data required to be submitted by health care  
 830 facilities, health care providers, or health insurers may ~~shall~~  
 831 not include specific provider contract reimbursement  
 832 information. However, such specific provider reimbursement data

833 shall be reasonably available for onsite inspection by the  
 834 agency as is necessary to carry out the agency's regulatory  
 835 duties. Any such data obtained by the agency as a result of  
 836 onsite inspections may not be used by the state for purposes of  
 837 direct provider contracting and are confidential and exempt from  
 838 ~~the provisions of s. 119.07(1) and s. 24(a), Art. I of the State~~  
 839 Constitution.

840 (e) A requirement to submit data shall be adopted by rule  
 841 if the submission of data is being required of all members of  
 842 any type of health care facility, health care provider, or  
 843 health insurer. Rules are not required, however, for the  
 844 submission of data for a special study mandated by the  
 845 Legislature or when information is being requested for a single  
 846 health care facility, health care provider, or health insurer.

847 Section 4. Subsections (8), (9), and (10) of section  
 848 408.810, Florida Statutes, are renumbered as subsections (9),  
 849 (10), and (11), respectively, and a new subsection (8) is added  
 850 to that section to read:

851 408.810 Minimum licensure requirements.—In addition to the  
 852 licensure requirements specified in this part, authorizing  
 853 statutes, and applicable rules, each applicant and licensee must  
 854 comply with ~~the requirements of~~ this section in order to obtain  
 855 and maintain a license.

856 (8) Each licensee subject to s. 408.05(3)(d) shall submit  
 857 the patient safety culture survey or surveys to the agency in  
 858 accordance with applicable rules.

859 Section 5. Section 456.0575, Florida Statutes, is amended  
 860 to read:

861 456.0575 Duty to notify patients.—

862 (1) Every licensed health care practitioner shall inform  
 863 each patient, or an individual identified pursuant to s.  
 864 765.401(1), in person about adverse incidents that result in  
 865 serious harm to the patient. Notification of outcomes of care  
 866 that result in harm to the patient under this section does ~~shall~~  
 867 not constitute an acknowledgment of admission of liability, nor  
 868 can such notifications be introduced as evidence.

869 (2) Every licensed health care practitioner shall provide  
 870 upon request by a patient, before providing any nonemergency  
 871 medical services in a facility licensed under chapter 395, a  
 872 written, good faith estimate of reasonably anticipated charges  
 873 to treat the patient's condition at the facility. The health  
 874 care practitioner must provide the estimate to the patient  
 875 within 3 business days after receiving the request and is not  
 876 required to adjust the estimate for any potential insurance  
 877 coverage. The health care practitioner must inform the patient  
 878 that he or she may contact his or her health insurer or health  
 879 maintenance organization for additional information concerning  
 880 cost-sharing responsibilities. The health care practitioner must  
 881 provide information to uninsured patients and insured patients  
 882 for whom the practitioner is not a network provider or preferred  
 883 provider which discloses the practitioner's financial assistance  
 884 policy, including the application process, payment plans,

885 discounts, or other available assistance, and the practitioner's  
 886 charity care policy and collection procedures. Such estimate  
 887 does not preclude the actual charges from exceeding the  
 888 estimate. Failure to provide the estimate in accordance with  
 889 this subsection shall result in disciplinary action against the  
 890 health care practitioner and a daily fine of \$500 until the  
 891 estimate is provided to the patient. The total fine may not  
 892 exceed \$5,000.

893 Section 6. Section 627.6385, Florida Statutes, is created  
 894 to read:

895 627.6385 Disclosures to policyholders; calculations of  
 896 cost sharing.-

897 (1) Each health insurer shall make available on its  
 898 website:

899 (a) A method for policyholders to estimate their  
 900 copayments, deductibles, and other cost-sharing responsibilities  
 901 for health care services and procedures. Such method of making  
 902 an estimate shall be based on service bundles established  
 903 pursuant to s. 408.05(3)(c). Estimates do not preclude the  
 904 actual copayment, coinsurance percentage, or deductible,  
 905 whichever is applicable, from exceeding the estimate.

906 1. Estimates shall be calculated according to the policy  
 907 and known plan usage during the coverage period.

908 2. Estimates shall be made available based on providers  
 909 that are in-network and out-of-network.

910 3. A policyholder must be able to create estimates by any

911 combination of the service bundles established pursuant to s.  
 912 408.05(3)(c), a specified provider, or a comparison of  
 913 providers.

914 (b) A method for policyholders to estimate their  
 915 copayments, deductibles, and other cost-sharing responsibilities  
 916 based on a personalized estimate of charges received from a  
 917 facility pursuant to s. 395.301 or a practitioner pursuant to s.  
 918 456.0575.

919 (c) A hyperlink to the health information, including, but  
 920 not limited to, service bundles and quality of care information,  
 921 which is disseminated by the Agency for Health Care  
 922 Administration pursuant to s. 408.05(3).

923 (2) Each health insurer shall include in every policy  
 924 delivered or issued for delivery to any person in the state or  
 925 in materials provided as required by s. 627.64725 notice that  
 926 the information required by this section is available  
 927 electronically and the address of its website.

928 (3) Each health insurer that participates in the state  
 929 group health insurance plan created under s. 110.123 or Medicaid  
 930 managed care pursuant to part IV of chapter 409 shall contribute  
 931 all claims data from Florida policyholders to the contracted  
 932 vendor selected by the Agency for Health Care Administration  
 933 under s. 408.05(3)(c).

934 Section 7. Subsection (6) of section 641.54, Florida  
 935 Statutes, is amended, present subsection (7) is renumbered as  
 936 subsection (8) and amended, and a new subsection (7) is added to

937 that section, to read:

938 641.54 Information disclosure.—

939 (6) Each health maintenance organization shall make  
 940 available to its subscribers on its website or by request the  
 941 estimated copayment ~~copay~~, coinsurance percentage, or  
 942 deductible, whichever is applicable, for any covered services as  
 943 described by the searchable bundles established on a consumer-  
 944 friendly, Internet-based platform pursuant to s. 408.05(3)(c) or  
 945 as described by a personalized estimate received from a facility  
 946 pursuant to s. 395.301 or a practitioner pursuant to s.  
 947 456.0575, the status of the subscriber's maximum annual out-of-  
 948 pocket payments for a covered individual or family, and the  
 949 status of the subscriber's maximum lifetime benefit. Such  
 950 estimate does ~~shall~~ not preclude the actual copayment ~~copay~~,  
 951 coinsurance percentage, or deductible, whichever is applicable,  
 952 from exceeding the estimate.

953 (7) Each health maintenance organization that participates  
 954 in the state group health insurance plan created under s.  
 955 110.123 or Medicaid managed care pursuant to part IV of chapter  
 956 409 shall contribute all claims data from Florida subscribers to  
 957 the contracted vendor selected by the Agency for Health Care  
 958 Administration under s. 408.05(3)(c).

959 ~~(8)(7)~~ Each health maintenance organization shall make  
 960 available on its ~~Internet~~ website a hyperlink ~~link~~ to the health  
 961 information ~~performance outcome and financial data~~ that is  
 962 disseminated ~~published~~ by the Agency for Health Care

963 Administration pursuant to s. 408.05(3) ~~408.05(3)(k)~~ and shall  
 964 include in every policy delivered or issued for delivery to any  
 965 person in the state or in any materials provided as required by  
 966 s. 627.64725 notice that such information is available  
 967 electronically and the address of its ~~Internet~~ website.

968 Section 8. Paragraph (n) is added to subsection (2) of  
 969 section 409.967, Florida Statutes, to read:

970 409.967 Managed care plan accountability.—

971 (2) The agency shall establish such contract requirements  
 972 as are necessary for the operation of the statewide managed care  
 973 program. In addition to any other provisions the agency may deem  
 974 necessary, the contract must require:

975 (n) Transparency.—Managed care plans shall comply with ss.  
 976 627.6385(3) and 641.54(7).

977 Section 9. Paragraph (d) of subsection (3) of section  
 978 110.123, Florida Statutes, is amended to read:

979 110.123 State group insurance program.—

980 (3) STATE GROUP INSURANCE PROGRAM.—

981 (d)1. Notwithstanding ~~the provisions of~~ chapter 287 and  
 982 the authority of the department, for the purpose of protecting  
 983 the health of, and providing medical services to, state  
 984 employees participating in the state group insurance program,  
 985 the department may contract to retain the services of  
 986 professional administrators for the state group insurance  
 987 program. The agency shall follow good purchasing practices of  
 988 state procurement to the extent practicable under the

989 | circumstances.

990 |         2. Each vendor in a major procurement, and any other  
 991 | vendor if the department deems it necessary to protect the  
 992 | state's financial interests, shall, at the time of executing any  
 993 | contract with the department, post an appropriate bond with the  
 994 | department in an amount determined by the department to be  
 995 | adequate to protect the state's interests but not higher than  
 996 | the full amount estimated to be paid annually to the vendor  
 997 | under the contract.

998 |         3. Each major contract entered into by the department  
 999 | pursuant to this section shall contain a provision for payment  
 1000 | of liquidated damages to the department for material  
 1001 | noncompliance by a vendor with a contract provision. The  
 1002 | department may require a liquidated damages provision in any  
 1003 | contract if the department deems it necessary to protect the  
 1004 | state's financial interests.

1005 |         4. Section ~~The provisions of s. 120.57(3)~~ applies ~~apply~~ to  
 1006 | the department's contracting process, except:

1007 |         a. A formal written protest of any decision, intended  
 1008 | decision, or other action subject to protest shall be filed  
 1009 | within 72 hours after receipt of notice of the decision,  
 1010 | intended decision, or other action.

1011 |         b. As an alternative to any provision of s. 120.57(3), the  
 1012 | department may proceed with the bid selection or contract award  
 1013 | process if the director of the department sets forth, in  
 1014 | writing, particular facts and circumstances that ~~which~~

1015 demonstrate the necessity of continuing the procurement process  
 1016 or the contract award process in order to avoid a substantial  
 1017 disruption to the provision of any scheduled insurance services.

1018 5. The department shall make arrangements as necessary to  
 1019 contribute claims data of the state group health insurance plan  
 1020 to the contracted vendor selected by the Agency for Health Care  
 1021 Administration pursuant to s. 408.05(3)(c).

1022 6. Each contracted vendor for the state group health  
 1023 insurance plan shall contribute Florida claims data to the  
 1024 contracted vendor selected by the Agency for Health Care  
 1025 Administration pursuant to s. 408.05(3)(c).

1026 Section 10. Subsection (3) of section 20.42, Florida  
 1027 Statutes, is amended to read:

1028 20.42 Agency for Health Care Administration.—

1029 (3) The department shall be the chief health policy and  
 1030 planning entity for the state. The department is responsible for  
 1031 health facility licensure, inspection, and regulatory  
 1032 enforcement; investigation of consumer complaints related to  
 1033 health care facilities and managed care plans; the  
 1034 implementation of the certificate of need program; the operation  
 1035 of the Florida Center for Health Information and Transparency  
 1036 ~~Policy Analysis~~; the administration of the Medicaid program; the  
 1037 administration of the contracts with the Florida Healthy Kids  
 1038 Corporation; the certification of health maintenance  
 1039 organizations and prepaid health clinics as set forth in part  
 1040 III of chapter 641; and any other duties prescribed by statute

1041 or agreement.

1042 Section 11. Paragraph (c) of subsection (4) of section  
1043 381.026, Florida Statutes, is amended to read:

1044 381.026 Florida Patient's Bill of Rights and  
1045 Responsibilities.-

1046 (4) RIGHTS OF PATIENTS.-Each health care facility or  
1047 provider shall observe the following standards:

1048 (c) Financial information and disclosure.-

1049 1. A patient has the right to be given, upon request, by  
1050 the responsible provider, his or her designee, or a  
1051 representative of the health care facility full information and  
1052 necessary counseling on the availability of known financial  
1053 resources for the patient's health care.

1054 2. A health care provider or a health care facility shall,  
1055 upon request, disclose to each patient who is eligible for  
1056 Medicare, before treatment, whether the health care provider or  
1057 the health care facility in which the patient is receiving  
1058 medical services accepts assignment under Medicare reimbursement  
1059 as payment in full for medical services and treatment rendered  
1060 in the health care provider's office or health care facility.

1061 3. A primary care provider may publish a schedule of  
1062 charges for the medical services that the provider offers to  
1063 patients. The schedule must include the prices charged to an  
1064 uninsured person paying for such services by cash, check, credit  
1065 card, or debit card. The schedule must be posted in a  
1066 conspicuous place in the reception area of the provider's office

1067 and must include, but is not limited to, the 50 services most  
 1068 frequently provided by the primary care provider. The schedule  
 1069 may group services by three price levels, listing services in  
 1070 each price level. The posting must be at least 15 square feet in  
 1071 size. A primary care provider who publishes and maintains a  
 1072 schedule of charges for medical services is exempt from the  
 1073 license fee requirements for a single period of renewal of a  
 1074 professional license under chapter 456 for that licensure term  
 1075 and is exempt from the continuing education requirements of  
 1076 chapter 456 and the rules implementing those requirements for a  
 1077 single 2-year period.

1078 4. If a primary care provider publishes a schedule of  
 1079 charges pursuant to subparagraph 3., he or she must continually  
 1080 post it at all times for the duration of active licensure in  
 1081 this state when primary care services are provided to patients.  
 1082 If a primary care provider fails to post the schedule of charges  
 1083 in accordance with this subparagraph, the provider shall be  
 1084 required to pay any license fee and comply with any continuing  
 1085 education requirements for which an exemption was received.

1086 5. A health care provider or a health care facility shall,  
 1087 upon request, furnish a person, before the provision of medical  
 1088 services, a reasonable estimate of charges for such services.  
 1089 The health care provider or the health care facility shall  
 1090 provide an uninsured person, before the provision of a planned  
 1091 nonemergency medical service, a reasonable estimate of charges  
 1092 for such service and information regarding the provider's or

1093 facility's discount or charity policies for which the uninsured  
 1094 person may be eligible. Such estimates by a primary care  
 1095 provider must be consistent with the schedule posted under  
 1096 subparagraph 3. Estimates shall, to the extent possible, be  
 1097 written in language comprehensible to an ordinary layperson.  
 1098 Such reasonable estimate does not preclude the health care  
 1099 provider or health care facility from exceeding the estimate or  
 1100 making additional charges based on changes in the patient's  
 1101 condition or treatment needs.

1102         6. Each licensed facility, except a facility operating  
 1103 exclusively as a state mental health treatment facility or as a  
 1104 mobile surgical facility, not operated by the state shall make  
 1105 available to the public on its ~~Internet~~ website or by other  
 1106 electronic means a description of and a hyperlink link to the  
 1107 health information performance outcome and financial data that  
 1108 is disseminated ~~published~~ by the agency pursuant to s. 408.05(3)  
 1109 ~~408.05(3)(k)~~. The facility shall place a notice in the reception  
 1110 area that such information is available electronically and the  
 1111 website address. The licensed facility may indicate that the  
 1112 pricing information is based on a compilation of charges for the  
 1113 average patient and that each patient's statement or bill may  
 1114 vary from the average depending upon the severity of illness and  
 1115 individual resources consumed. The licensed facility may also  
 1116 indicate that the price of service is negotiable for eligible  
 1117 patients based upon the patient's ability to pay.

1118         7. A patient has the right to receive a copy of an

1119 itemized statement or bill upon request. A patient has a right  
 1120 to be given an explanation of charges upon request.

1121 Section 12. Paragraph (e) of subsection (2) of section  
 1122 395.602, Florida Statutes, is amended to read:

1123 395.602 Rural hospitals.—

1124 (2) DEFINITIONS.—As used in this part, the term:

1125 (e) "Rural hospital" means an acute care hospital licensed  
 1126 under this chapter, having 100 or fewer licensed beds and an  
 1127 emergency room, which is:

1128 1. The sole provider within a county with a population  
 1129 density of up to 100 persons per square mile;

1130 2. An acute care hospital, in a county with a population  
 1131 density of up to 100 persons per square mile, which is at least  
 1132 30 minutes of travel time, on normally traveled roads under  
 1133 normal traffic conditions, from any other acute care hospital  
 1134 within the same county;

1135 3. A hospital supported by a tax district or subdistrict  
 1136 whose boundaries encompass a population of up to 100 persons per  
 1137 square mile;

1138 4. A hospital with a service area that has a population of  
 1139 up to 100 persons per square mile. As used in this subparagraph,  
 1140 the term "service area" means the fewest number of zip codes  
 1141 that account for 75 percent of the hospital's discharges for the  
 1142 most recent 5-year period, based on information available from  
 1143 the hospital inpatient discharge database in the Florida Center  
 1144 for Health Information and Transparency ~~Policy Analysis~~ at the

1145 agency; or

1146 5. A hospital designated as a critical access hospital, as  
1147 defined in s. 408.07.

1148

1149 Population densities used in this paragraph must be based upon  
1150 the most recently completed United States census. A hospital  
1151 that received funds under s. 409.9116 for a quarter beginning no  
1152 later than July 1, 2002, is deemed to have been and shall  
1153 continue to be a rural hospital from that date through June 30,  
1154 2021, if the hospital continues to have up to 100 licensed beds  
1155 and an emergency room. An acute care hospital that has not  
1156 previously been designated as a rural hospital and that meets  
1157 the criteria of this paragraph shall be granted such designation  
1158 upon application, including supporting documentation, to the  
1159 agency. A hospital that was licensed as a rural hospital during  
1160 the 2010-2011 or 2011-2012 fiscal year shall continue to be a  
1161 rural hospital from the date of designation through June 30,  
1162 2021, if the hospital continues to have up to 100 licensed beds  
1163 and an emergency room.

1164 Section 13. Section 395.6025, Florida Statutes, is amended  
1165 to read:

1166 395.6025 Rural hospital replacement facilities.—

1167 Notwithstanding ~~the provisions of~~ s. 408.036, a hospital defined  
1168 as a statutory rural hospital in accordance with s. 395.602, or  
1169 a not-for-profit operator of rural hospitals, is not required to  
1170 obtain a certificate of need for the construction of a new

1171 hospital located in a county with a population of at least  
 1172 15,000 but no more than 18,000 and a density of fewer ~~less~~ than  
 1173 30 persons per square mile, or a replacement facility, provided  
 1174 that the replacement, or new, facility is located within 10  
 1175 miles of the site of the currently licensed rural hospital and  
 1176 within the current primary service area. As used in this  
 1177 section, the term "service area" means the fewest number of zip  
 1178 codes that account for 75 percent of the hospital's discharges  
 1179 for the most recent 5-year period, based on information  
 1180 available from the hospital inpatient discharge database in the  
 1181 Florida Center for Health Information and Transparency Policy  
 1182 ~~Analysis~~ at the Agency for Health Care Administration.

1183 Section 14. Paragraph (c) of subsection (4) of section  
 1184 400.991, Florida Statutes, is amended to read:

1185 400.991 License requirements; background screenings;  
 1186 prohibitions.-

1187 (4) In addition to the requirements of part II of chapter  
 1188 408, the applicant must file with the application satisfactory  
 1189 proof that the clinic is in compliance with this part and  
 1190 applicable rules, including:

1191 (c) Proof of financial ability to operate as required  
 1192 under s. 408.810(9) ~~408.810(8)~~. As an alternative to submitting  
 1193 proof of financial ability to operate as required under s.  
 1194 408.810(8), the applicant may file a surety bond of at least  
 1195 \$500,000 which guarantees that the clinic will act in full  
 1196 conformity with all legal requirements for operating a clinic,

1197 payable to the agency. The agency may adopt rules to specify  
 1198 related requirements for such surety bond.

1199 Section 15. Paragraph (d) of subsection (43) of section  
 1200 408.07, Florida Statutes, is amended to read:

1201 408.07 Definitions.—As used in this chapter, with the  
 1202 exception of ss. 408.031-408.045, the term:

1203 (43) "Rural hospital" means an acute care hospital  
 1204 licensed under chapter 395, having 100 or fewer licensed beds  
 1205 and an emergency room, and which is:

1206 (d) A hospital with a service area that has a population  
 1207 of 100 persons or fewer per square mile. As used in this  
 1208 paragraph, the term "service area" means the fewest number of  
 1209 zip codes that account for 75 percent of the hospital's  
 1210 discharges for the most recent 5-year period, based on  
 1211 information available from the hospital inpatient discharge  
 1212 database in the Florida Center for Health Information and  
 1213 Transparency Policy Analysis at the Agency for Health Care  
 1214 Administration; or

1215  
 1216 Population densities used in this subsection must be based upon  
 1217 the most recently completed United States census. A hospital  
 1218 that received funds under s. 409.9116 for a quarter beginning no  
 1219 later than July 1, 2002, is deemed to have been and shall  
 1220 continue to be a rural hospital from that date through June 30,  
 1221 2015, if the hospital continues to have 100 or fewer licensed  
 1222 beds and an emergency room. An acute care hospital that has not

1223 | previously been designated as a rural hospital and that meets  
 1224 | the criteria of this subsection shall be granted such  
 1225 | designation upon application, including supporting  
 1226 | documentation, to the Agency for Health Care Administration.

1227 |       Section 16. Paragraph (a) of subsection (4) of section  
 1228 | 408.18, Florida Statutes, is amended to read:

1229 |       408.18 Health Care Community Antitrust Guidance Act;  
 1230 | antitrust no-action letter; market-information collection and  
 1231 | education.—

1232 |       (4) (a) Members of the health care community who seek  
 1233 | antitrust guidance may request a review of their proposed  
 1234 | business activity by the Attorney General's office. In  
 1235 | conducting its review, the Attorney General's office may seek  
 1236 | whatever documentation, data, or other material it deems  
 1237 | necessary from the Agency for Health Care Administration, the  
 1238 | Florida Center for Health Information and Transparency Policy  
 1239 | ~~Analysis~~, and the Office of Insurance Regulation of the  
 1240 | Financial Services Commission.

1241 |       Section 17. Paragraph (a) of subsection (1) of section  
 1242 | 408.8065, Florida Statutes, is amended to read:

1243 |       408.8065 Additional licensure requirements for home health  
 1244 | agencies, home medical equipment providers, and health care  
 1245 | clinics.—

1246 |       (1) An applicant for initial licensure, or initial  
 1247 | licensure due to a change of ownership, as a home health agency,  
 1248 | home medical equipment provider, or health care clinic shall:

1249 (a) Demonstrate financial ability to operate, as required  
 1250 under s. 408.810(9) ~~408.810(8)~~ and this section. If the  
 1251 applicant's assets, credit, and projected revenues meet or  
 1252 exceed projected liabilities and expenses, and the applicant  
 1253 provides independent evidence that the funds necessary for  
 1254 startup costs, working capital, and contingency financing exist  
 1255 and will be available as needed, the applicant has demonstrated  
 1256 the financial ability to operate.

1257

1258 All documents required under this subsection must be prepared in  
 1259 accordance with generally accepted accounting principles and may  
 1260 be in a compilation form. The financial statements must be  
 1261 signed by a certified public accountant.

1262 Section 18. Section 408.820, Florida Statutes, is amended  
 1263 to read:

1264 408.820 Exemptions.—Except as prescribed in authorizing  
 1265 statutes, the following exemptions shall apply to specified  
 1266 requirements of this part:

1267 (1) Laboratories authorized to perform testing under the  
 1268 Drug-Free Workplace Act, as provided under ss. 112.0455 and  
 1269 440.102, are exempt from s. 408.810(5)-(11) ~~408.810(5)-(10)~~.

1270 (2) Birth centers, as provided under chapter 383, are  
 1271 exempt from s. 408.810(7)-(11) ~~408.810(7)-(10)~~.

1272 (3) Abortion clinics, as provided under chapter 390, are  
 1273 exempt from s. 408.810(7)-(11) ~~408.810(7)-(10)~~.

1274 (4) Crisis stabilization units, as provided under parts I

1275 and IV of chapter 394, are exempt from s. 408.810(9)-(11)  
 1276 ~~408.810(8)-(10)~~.

1277 (5) Short-term residential treatment facilities, as  
 1278 provided under parts I and IV of chapter 394, are exempt from s.  
 1279 408.810(9)-(11) ~~408.810(8)-(10)~~.

1280 (6) Residential treatment facilities, as provided under  
 1281 part IV of chapter 394, are exempt from s. 408.810(9)-(11)  
 1282 ~~408.810(8)-(10)~~.

1283 (7) Residential treatment centers for children and  
 1284 adolescents, as provided under part IV of chapter 394, are  
 1285 exempt from s. 408.810(9)-(11) ~~408.810(8)-(10)~~.

1286 (8) Hospitals, as provided under part I of chapter 395,  
 1287 are exempt from s. 408.810(7), (9), and (10) ~~408.810(7)-(9)~~.

1288 (9) Ambulatory surgical centers, as provided under part I  
 1289 of chapter 395, are exempt from s. 408.810(7), (9), (10), and  
 1290 (11) ~~408.810(7)-(10)~~.

1291 (10) Mobile surgical facilities, as provided under part I  
 1292 of chapter 395, are exempt from s. 408.810(7)-(11) ~~408.810(7)-~~  
 1293 ~~(10)~~.

1294 (11) Health care risk managers, as provided under part I  
 1295 of chapter 395, are exempt from ss. 408.806(7), 408.810(4)-(11)  
 1296 ~~408.810(4)-(10)~~, and 408.811.

1297 (12) Nursing homes, as provided under part II of chapter  
 1298 400, are exempt from ss. 408.810(7) and 408.813(2).

1299 (13) Assisted living facilities, as provided under part I  
 1300 of chapter 429, are exempt from s. 408.810(11) ~~408.810(10)~~.

1301 (14) Home health agencies, as provided under part III of  
 1302 chapter 400, are exempt from s. 408.810(11) ~~408.810(10)~~.

1303 (15) Nurse registries, as provided under part III of  
 1304 chapter 400, are exempt from s. 408.810(6) and (11) ~~(10)~~.

1305 (16) Companion services or homemaker services providers,  
 1306 as provided under part III of chapter 400, are exempt from s.  
 1307 408.810(6)-(11) ~~408.810(6)-(10)~~.

1308 (17) Adult day care centers, as provided under part III of  
 1309 chapter 429, are exempt from s. 408.810(11) ~~408.810(10)~~.

1310 (18) Adult family-care homes, as provided under part II of  
 1311 chapter 429, are exempt from s. 408.810(7)-(11) ~~408.810(7)-(10)~~.

1312 (19) Homes for special services, as provided under part V  
 1313 of chapter 400, are exempt from s. 408.810(7)-(11) ~~408.810(7)-~~  
 1314 ~~(10)~~.

1315 (20) Transitional living facilities, as provided under  
 1316 part XI of chapter 400, are exempt from s. 408.810(11)  
 1317 ~~408.810(10)~~.

1318 (21) Prescribed pediatric extended care centers, as  
 1319 provided under part VI of chapter 400, are exempt from s.  
 1320 408.810(11) ~~408.810(10)~~.

1321 (22) Home medical equipment providers, as provided under  
 1322 part VII of chapter 400, are exempt from s. 408.810(11)  
 1323 ~~408.810(10)~~.

1324 (23) Intermediate care facilities for persons with  
 1325 developmental disabilities, as provided under part VIII of  
 1326 chapter 400, are exempt from s. 408.810(7).

1327 (24) Health care services pools, as provided under part IX  
 1328 of chapter 400, are exempt from s. 408.810(6)-(11) ~~408.810(6)-~~  
 1329 ~~(10)~~.

1330 (25) Health care clinics, as provided under part X of  
 1331 chapter 400, are exempt from s. 408.810(6), (7), and (11) ~~(10)~~.

1332 (26) Clinical laboratories, as provided under part I of  
 1333 chapter 483, are exempt from s. 408.810(5)-(11) ~~408.810(5)-(10)~~.

1334 (27) Multiphasic health testing centers, as provided under  
 1335 part II of chapter 483, are exempt from s. 408.810(5)-(11)  
 1336 ~~408.810(5)-(10)~~.

1337 (28) Organ, tissue, and eye procurement organizations, as  
 1338 provided under part V of chapter 765, are exempt from s.  
 1339 408.810(5)-(11) ~~408.810(5)-(10)~~.

1340 Section 19. Section 465.0244, Florida Statutes, is amended  
 1341 to read:

1342 465.0244 Information disclosure.—Every pharmacy shall make  
 1343 available on its ~~Internet~~ website a hyperlink link to the health  
 1344 information ~~performance outcome and financial data~~ that is  
 1345 disseminated ~~published~~ by the Agency for Health Care  
 1346 Administration pursuant to s. 408.05(3) ~~408.05(3)(k)~~ and shall  
 1347 place in the area where customers receive filled prescriptions  
 1348 notice that such information is available electronically and the  
 1349 address of its ~~Internet~~ website.

1350 Section 20. Subsection (2) of section 627.6499, Florida  
 1351 Statutes, is amended to read:

1352 627.6499 Reporting by insurers and third-party

1353 administrators.-

1354 (2) Each health insurance issuer shall make available on  
 1355 its Internet website a hyperlink ~~link~~ to the health information  
 1356 ~~performance outcome and financial data~~ that is disseminated  
 1357 ~~published~~ by the Agency for Health Care Administration pursuant  
 1358 to s. 408.05(3) ~~408.05(3)(k)~~ and shall include in every policy  
 1359 delivered or issued for delivery to any person in the state or  
 1360 in any materials provided as required by s. 627.64725 notice  
 1361 that such information is available electronically and the  
 1362 address of its ~~Internet~~ website.

1363 Section 21. This act shall take effect July 1, 2016.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___	(Y/N)
ADOPTED AS AMENDED	___	(Y/N)
ADOPTED W/O OBJECTION	___	(Y/N)
FAILED TO ADOPT	___	(Y/N)
WITHDRAWN	___	(Y/N)
OTHER	_____	

1 Committee/Subcommittee hearing bill: Health Care Appropriations  
2 Subcommittee

3 Representative Sprowls offered the following:

4  
5 **Amendment**

6 Remove lines 692-708 and insert:

7 ~~(a) The Legislature intends that funding for the Florida~~  
8 ~~Center for Health Information and Transparency Policy Analysis~~  
9 ~~be appropriated from the General Revenue Fund.~~

10 (a) ~~(b)~~ The Florida Center for Health Information and  
11 Transparency Policy Analysis may apply for and receive and  
12 accept grants, gifts, and other payments, including property and  
13 services, from any governmental or other public or private  
14 entity or person and make arrangements as to the use of same,  
15 including the undertaking of special studies and other projects  
16 relating to health-care-related topics. ~~Funds obtained pursuant~~

Amendment No. 1

17 ~~to this paragraph may not be used to offset annual~~  
18 ~~appropriations from the General Revenue Funds.~~

19 (b)-(e) The center may charge such reasonable fees for  
20 services as the agency prescribes by rule. The established fees  
21 may not exceed the reasonable cost for such services. Fees  
22 ~~collected may not be used to offset annual appropriations from~~  
23 ~~the General Revenue Fund.~~

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___	(Y/N)
ADOPTED AS AMENDED	___	(Y/N)
ADOPTED W/O OBJECTION	___	(Y/N)
FAILED TO ADOPT	___	(Y/N)
WITHDRAWN	___	(Y/N)
OTHER	_____	

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Sprowls offered the following:

**Amendment (with title amendment)**

Between lines 1362 and 1363, insert:

Section 21. For the 2016-2017 fiscal year, one full-time equivalent position, with associated salary rate of 41,106, is authorized and the sums of \$952,919 in recurring funds and \$3,100,000 in nonrecurring funds from the Health Care Trust Fund are hereby appropriated to the Agency for Health Care Administration for the purpose of implementing the requirements of this act.

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

Remove line 84 and insert:

Amendment No. 2

18 providing an appropriation; providing an effective date.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7087      PCB SCAHA 16-01      Telehealth  
**SPONSOR(S):** Select Committee on Affordable Healthcare Access, Sprowls  
**TIED BILLS:**                      **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Select Committee on Affordable Healthcare Access	14 Y, 0 N	McElroy	Calamas
1) Health Care Appropriations Subcommittee		Garner 	Pridgeon 
2) Health & Human Services Committee			

### SUMMARY ANALYSIS

The bill creates s. 456.47, F.S., relating to the use of telehealth to provide health care services.

The bill authorizes Florida licensed health care professionals to use telehealth to deliver health care services within their respective scopes of practice. The bill also authorizes out-of-state health care professionals to use telehealth to deliver health care services to Florida patients if they register with the Department of Health (DOH) or the applicable board, meet certain eligibility requirements, and pay a fee. A registered telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients, but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

The bill requires a telehealth provider to use the same standard of care applicable to health care services provided in-person. Additionally, the telehealth provider must conduct an in-person physical examination of the patient prior to providing services through telehealth, unless the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth.

The bill places no service location limitations on health care professionals or patients. Specifically, both the telehealth provider and the patient may be in any location at the time the services are rendered.

The bill allows health care providers who are authorized to prescribe a controlled substance to use telehealth to do so. Telehealth may not be used to prescribe a controlled substance to treat chronic nonmalignant pain, except in certain limited circumstances.

The bill requires a telehealth provider to document the services rendered in the patient's medical records according to the same standard as that required for in-person services. The bill requires those records to be confidential in accordance with the current confidentiality requirements placed upon health care facilities and health care professionals providing in-person services.

The bill requires the Agency for Health Care Administration (AHCA), with assistance from DOH and the Office of Insurance Regulation (OIR), to survey health care providers, facilities and insurers on telehealth utilization and coverage. The bill requires AHCA to report on the surveys to the Governor, Senate President and Speaker of the House of Representatives.

The bill has a negative fiscal impact of \$334,387 on DOH for conducting the survey; however, the bill requires the survey to be conducted within existing resources. AHCA and OIR can absorb the impact with existing resources. The DOH will experience a workload increase for the registration of out of state telehealth providers. DOH will require 4 full time equivalent positions and budget authority of \$276,917 to perform the additional responsibilities. The costs will be offset by revenues generated by the license fee. The bill does not appear to have a fiscal impact on local government.

The bill provides an effective date of July 1, 2015.

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### Present Situation

##### Health Care Professional Shortage

There is currently a physician shortage in the U.S.<sup>1</sup> This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population<sup>2</sup> and the passage of the Patient Protection and Affordable Care Act.<sup>3</sup> Aging populations create a disproportionately higher health care demand.<sup>4</sup> Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services. There are several other factors which will likely increase the demand for a larger health care workforce. These include:<sup>5</sup>

- Shortage of health care professionals being educated, trained and licensed;
- Lack of specialists and health facilities in rural areas;
- Adverse events, injuries and illness at hospitals and physician's offices; and
- Need to improve community and population health.

Florida is not immune to the national problem and is experiencing a health care provider shortage itself. This is evidenced by the fact that for just primary care, dental care and mental health there are 615 federally designated Health Professional Shortage Areas (HPSA) within the state.<sup>6</sup> It would take 916 primary care<sup>7</sup>, 860 dental care<sup>8</sup> and 83 mental health<sup>9</sup> practitioners to eliminate these shortage areas.

Numerous solutions have been proposed to combat the health care professional shortage. These proposals seek to address both the current and future shortages. Long-term proposals include the creation of new scholarships and residency programs for emerging health care providers.<sup>10</sup> These proposals address the shortage in the future by creating new health care professionals. Short-term

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<sup>1</sup> For example, as of June 19, 2014, the U.S. Department of Health and Human Services has designated 6,100 Primary Care Health Professional Shortage Area (HPSA) (requiring 8,200 additional primary care physicians to eliminate the shortage), 4,900 Dental HPSAs (requiring 7,300 additional dentists to eliminate the shortage), and 4,000 Mental Health HPSAs (requiring 2,800 additional psychiatrists to eliminate the shortage). This information is available at the U.S. Department of Health and Human Services' Health Resources and Services Administration's website, <http://www.hrsa.gov/shortage/> (last visited on January 5, 2016).

<sup>2</sup> There will be a significant increase in the U.S. population, estimated to grow 20 percent (to 363 million) between 2008-2030.

<sup>3</sup> *Department of Health and Human Services Strategic Plan: Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce*, U.S. Department of Health and Human Services, <http://www.hhs.gov/secretary/about/goal5.html> (last visited on January 5, 2016).

<sup>4</sup> One analysis measured current primary care utilization (office visits) and projected the impact of population increases, aging, and insured status changes. The study found that the total number of office visits to primary care physicians will increase from 462 million in 2008 to 565 million in 2025, and (because of aging) the average number of visits will increase from 1.60 to 1.66. The study concluded that the U.S. will require 51,880 additional primary care physicians by 2025. Petterson, Stephen M., et al., "Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025", *Annals of Family Medicine*, vol. 10, No. 6, Nov./Dec. 2012, available at: <http://www.annfam.org/content/10/6/503.full.pdf+html> (last visited on January 5, 2016).

<sup>5</sup> *Telemedicine: An Important Force in the Transformation of Healthcare*, Matthew A. Hein, June 25, 2009.

<sup>6</sup> *Providers & Service Use Indicators*, Kaiser Family Foundation. <http://kff.org/state-category/providers-service-use/access-to-care/> (last visited on January 5, 2016).

<sup>7</sup> *Primary Care Health Professional Shortage Areas (HPSAs)*, Kaiser Family Foundation. <http://kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/> (last visited on January 5, 2016).

<sup>8</sup> *Dental Care Health Professional Shortage Areas (HPSAs)*, Kaiser Family Foundation. <http://kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/> (last visited on January 5, 2016).

<sup>9</sup> *Mental Health Professional Shortage Areas (HPSAs)*, Kaiser Family Foundation. <http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/> (last visited on January 5, 2016).

<sup>10</sup> U.S. Department of Health and Human Services, *supra* note 3.

proposals include broadening the scope of practice for certain health care professionals<sup>11</sup> and more efficient utilization of our existing workforce through the expanded use of telehealth.<sup>12</sup>

## Telehealth

There is no universally accepted definition of telehealth. In broad terms, telehealth is:

The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment<sup>13</sup> and prevention of disease and injuries<sup>14</sup>, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.<sup>15</sup>

More specific definitions vary greatly from country to country, as well as between the numerous states, authorizing the use of telehealth to deliver health care services. In fact, definitions of telehealth occasionally differ between the various professions within a specific state.<sup>16</sup> There are, however, common elements among the varied definitions of telehealth.

Telehealth generally consists of synchronous and/or asynchronous transmittal of information.<sup>17</sup> Synchronous refers to the live<sup>18</sup> transmission of information between patient and provider during the same time period.<sup>19</sup> Asynchronous telehealth is the transfer of data over a period of time, and typically in separate time frames.<sup>20</sup> This is commonly referred to as “store and forward”. Definitions of telehealth also commonly contain restrictions related to the location where telehealth may be used. For example, the use of the “hub and spoke” model is a common location restriction. A hub site is the location from which specialty or consultative services originate, i.e., the provider. A spoke site is a remote site where the patient is presented during the telehealth encounter. Under this model, health services may be provided through telehealth only if the patient is located at a designated spoke site and the provider is located at a designated hub site.

Telehealth is a broad term which includes telemedicine and telemonitoring. Telemedicine is focused on the delivery of traditional clinical services, like diagnosis and treatment. Telemonitoring is the process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patient from a distance.<sup>21</sup> Telehealth more broadly

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<sup>11</sup> Id.

<sup>12</sup> *Department of Health and Human Services Strategic Plan: Goal 1: Strengthen the Nation's Health and Human Service Infrastructure and Workforce*, U.S. Department of Health and Human Services, <http://www.hhs.gov/secretary/about/goal5.html> (last visited on January 5, 2016).

<sup>13</sup> The University of Florida's Diabetes Center of Excellence utilizes telehealth to deliver treatment to children with diabetes and other endocrine problems who live in Volusia County. This allows the children to receive specialized treatment without the necessity of traveling from Volusia County to Gainesville. The Florida Department of Health's Children's Medical Services underwrites the program. <https://ufhealth.org/diabetes-center-excellence/telemedicine> (last visited on January 5, 2016).

<sup>14</sup> The University of South Florida has partnered with American Well to provide health care services to the residents of the Villages via telehealth. The goal is to reduce hospital admissions, readmission rates, and pharmacy costs, while maintaining Medicare beneficiaries in their homes rather than long-term care settings. <http://hscweb3.hsc.usf.edu/blog/2012/06/22/usf-health-and-american-well-to-bring-telehealth-to-seniors-living-at-the-villages/> (last visited on January 5, 2016).

<sup>15</sup> *Telemedicine: Opportunities and Developments in Member States, Global Observatory for Ehealth Series- Volume 2*, Section 1.2, page 9.

<sup>16</sup> *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, February 2015.

<sup>17</sup> The majority of telehealth definitions allow for both synchronous and asynchronous transmittal of information. Some definitions however omit asynchronous from the definition of telehealth.

<sup>18</sup> This is also referred to as “real time” or “interactive” telehealth.

<sup>19</sup> *Telemedicine Nomenclature*, American Telemedicine Association, located at <http://www.americantelemed.org/resources/nomenclature#.VOuc1KNOncs> (last visited on January 5, 2016). The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

<sup>20</sup> Id. A common example of synchronous telehealth is the transfer of x-rays or MRI images from one health care provider to another health care provider for review in the future.

<sup>21</sup> *Glossary and Acronyms*, U.S. Department of Health and Human Services <http://www.hrsa.gov/ruralhealth/about/telehealth/glossary.html> (last visited January 5, 2016).

includes non-clinical services, such as patient and professional health-related education, public health and health administration.<sup>22</sup>

Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, primary and specialty care services and health management.<sup>23</sup>

Telehealth, in its modern form,<sup>24</sup> started in the 1960s in large part driven by the military and space technology sectors.<sup>25</sup> Specifically, telehealth was used to remotely monitor physiological measurements of certain military and space program personnel. As this technology became more readily available to the civilian market, telehealth began to be used for linking physicians with patients in remote, rural areas. As advancements were made in telecommunication technology, the use of telehealth became more widespread to include not only rural areas but also urban communities. Due to recent technology advancements and general accessibility, the use of telehealth has spread rapidly and is now becoming integrated into the ongoing operations of hospitals, specialty departments, home health agencies, private physician offices as well as consumer's homes and workplaces.<sup>26</sup> In fact, there are currently an estimated 200 telehealth networks, with 3,500 service sites in the U.S.<sup>27</sup>

Telehealth is used to address several problems in the current health care system. Inadequate access to care is one of the primary obstacles to obtaining quality health care.<sup>28</sup> This occurs in both rural areas and urban communities.<sup>29</sup> Telehealth reduces the impact of this issue by providing a mechanism to deliver quality health care, irrespective of the location of a patient or a health care professional. Cost is another barrier to obtaining quality health care.<sup>30</sup> This includes the cost of travel to and from the health care facility, as well as related loss of wages from work absences. Costs are reduced through telehealth by decreasing the time and distance required to travel to the health care professional. Two more issues addressed through telehealth are the reutilization of health care services and hospital readmission. These often occur due to a lack of proper follow-up care by the patient<sup>31</sup> or a chronic condition.<sup>32</sup> These issues however can potentially be avoided through the use of telehealth and telemonitoring.

### Telehealth and Federal Law

Several federal laws and regulations apply to the delivery of health care services through telehealth.

#### *Prescribing Via the Internet*

Federal law specifically prohibits prescribing controlled substances via the Internet without an in-person evaluation. The federal regulation under 21 CFR §829 specifically states:

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<sup>22</sup> Id.

<sup>23</sup> *What is Telehealth?* U.S. Department of Health and Human Services.

<http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/whatistelehealth.html> (last visited January 5, 2016).

<sup>24</sup> Historically, telehealth can be traced back to the mid to late 19th century with one of the first published accounts occurring in the early 20th century when electrocardiograph data were transmitted over telephone wires. *Telemedicine: Opportunities and Developments in Member States, Global Observatory for Ehealth Series- Volume 2*, Section 1.2, page 9.

<sup>25</sup> *Telemedicine: Opportunities and Developments in Member States*, *supra* note 14.

<sup>26</sup> *What is Telemedicine*, American Telemedicine Association, <http://www.americantelemed.org/learn/what-is-telemedicine#.Uu6eGqNOncs> (last visited on January 5, 2016).

<sup>27</sup> *Telemedicine Frequently Asked Questions*, American Telemedicine Association, <http://www.americantelemed.org/learn/what-is-telemedicine/faqs#.Uu5vyaNOncf> (last visited on January 5, 2016).

<sup>28</sup> U.S. Department of Health and Human Services, *supra* note 10.

<sup>29</sup> Id.

<sup>30</sup> Id.

<sup>31</sup> Post-surgical examination subsequent to a patient's release from a hospital is a prime example. Specifically, infection can occur without proper follow-up and ultimately leads to a readmission to the hospital.

<sup>32</sup> For example, diabetes is a chronic condition which can benefit by treatment through telehealth.

No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed or dispensed by means of the Internet without a valid prescription.

A valid prescription is further defined under the same regulation as one issued by a practitioner who has conducted an in-person evaluation. The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.<sup>33</sup> However, the Ryan Haight Online Pharmacy Consumer Protection Act,<sup>34</sup> signed into law in October 2008, created an exception for the in-person medical evaluation for telehealth practitioners. The practitioner is still subject to the requirement that all controlled substance prescriptions be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice.

### *Medicare Coverage*

Specific telehealth<sup>35</sup> services delivered at designated sites are covered under Medicare. The Federal Centers for Medicare and Medicaid Services' regulations require both a distant site and a separate originating site (hub and spoke model) under their definition of telehealth. Asynchronous (store and forward) activities are only reimbursed under Medicare in federal demonstration projects.<sup>36</sup> To qualify for Medicare reimbursement, the originating site must be:

- Located in a federally defined rural county;
- Designated rural;<sup>37</sup> or
- Identified as a participant in a federal telemedicine demonstration project as of December 21, 2000.<sup>38</sup>

In addition, an originating site must be one of the following location types as further defined in federal law and regulation:

- The office of a physician or practitioner;
- A critical access hospital;
- A rural health clinic;
- A federally qualified health center;
- A hospital;
- A hospital-based or critical access hospital-based renal dialysis center (including satellites);
- A skilled nursing facility; or
- A community mental health center.<sup>39</sup>

### *Protection of Personal Health Information*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. Privacy rules were initially issued in 2000 by the U.S. Department of Health and Human Services and later modified in 2002.<sup>40</sup> These rules address the use and disclosure of an individual's personal health information as well as create standards for information security.

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<sup>33</sup> 21 CFR §829(e)(2).

<sup>34</sup> Ryan Haight Online Pharmacy Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).

<sup>35</sup> Medicare covers a broader set of services using the term telehealth. Medicare defines telehealth as the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

<sup>36</sup> Only two states have a federal demonstration project that meets these qualifications, Hawaii and Alaska.

<sup>37</sup> The rural definition was expanded through a final federal regulation released on December 10, 2013 to include health professional shortage areas located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. See 78 FR 74229, 74400-74402, 74812 (December 10, 2013).

<sup>38</sup> See 42 U.S.C. sec. 1395(m)(m)(4)(C)(i).

<sup>39</sup> See 42 U.S.C. sec. 1395(m)(m)(4)(C)(ii).

<sup>40</sup> *The Privacy Rule*, U.S. Department of Health and Human Services. <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacypolicy/> (last visited January 5, 2016).

Only certain entities are subject to HIPAA's provisions. These "covered entities" include<sup>41</sup>:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.

Covered entities are obligated to meet HIPAA's requirements to ensure privacy and confidentiality personal health information, regardless of the method in which the medical service is delivered.

In 2009, the Health Information Technology for Economic Clinical Health (HITECH) Act was enacted as part of American Recovery and Reinvestment Act (ARRA).<sup>42</sup> The HITECH Act promoted electronic exchange and use of health information by investing \$20 billion in health information technology infrastructure and incentives to encourage doctors and hospitals to use health information technology.<sup>43</sup> HITECH was intended to strengthen existing HIPAA security and privacy rules.<sup>44</sup> It expanded HIPAA to entities not previously covered; specifically, "business associates" now includes Regional Health Information Organizations, and Health Information Exchanges.<sup>45</sup> Similarly, it made changes to the privacy rule to better protect personal health information held, transferred, or used by covered entities.<sup>46</sup>

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in the electronic exchange of personal health information are subject to HIPAA and HITECH. These federal laws apply to covered entities in Florida, regardless of whether there is an express reference to them in Florida law.

### Telehealth Barriers

There are several barriers which impede the use of telehealth. These barriers include:<sup>47</sup>

- Lack of a standard definition for telehealth;
- Lack of standard regulations for the practice of telehealth;
- Licensure requirements which prohibit cross-state practice; and
- Restrictions on the location where telehealth services may be provided.

#### *Standardized Definition*

Lack of a standard definition<sup>48</sup> presents a barrier to the use of telehealth. As previously noted, there is no universally accepted definition. A health care professional is left to speculate as to whether the service he or she is providing constitutes telehealth. This can have far-reaching consequences which range from a denial of reimbursement for the services provided to an inquiry as to whether the services provided equate to the unlicensed practice of medicine. Florida law does not define telehealth.

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<sup>41</sup> *For Covered Entities and Business Associates*, U.S. Department of Health and Human Services.

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/> (last visited January 5, 2016).

<sup>42</sup> "Complying with the Health Information Technology for Economic and Clinical Health (HITECH) Act, HIPAA, Security and Privacy, and Electronic Health Records", Deloitte, December 2009, available at [https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us\\_lshc\\_LeadingPracticesandSolutionsforPrivacyandSecurityGuidelines\\_031710.pdf](https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_lshc_LeadingPracticesandSolutionsforPrivacyandSecurityGuidelines_031710.pdf), (last visited January 5, 2016).

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015.

<sup>48</sup> No two states define telehealth exactly alike, although some similarities exist between certain states. *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, February 2015.

## *Standardized Regulations*

The absence of a uniform regulatory structure governing the use of telehealth presents another barrier to its use. Currently, 7 states<sup>49</sup> do not have a statutory structure for the delivery of health care services through telehealth.<sup>50</sup> This absence places the burden upon individual professionals to determine what is appropriate, and invites health professional licensing boards to fill the regulatory gap. This can lead to an inconsistent regulation of telehealth amongst the varying health care professions and impede the use of telehealth.

For example, a common telehealth regulation is the requirement that a health care professional conduct an in-person examination of the patient prior to providing services via telehealth.<sup>51</sup> Many times an exception is expressly contained within the regulation which allows the in-person requirement to be met through telehealth.<sup>52</sup> This exception however can vary between the differing health care professions in the absence of a uniform regulation. For example, an audiologist may be authorized to conduct the initial evaluation through telehealth while a physical therapist is required to perform an in-person physical examination prior to providing services through telehealth. There may not be any reasonable justification for this disparate treatment.

## *Licensure*

Licensure requirements present one of the greatest barriers to the use of telehealth. States, not the federal government, license and regulate health care professionals.

Currently, 37 states prohibit health care professionals from providing health care services unless he or she is licensed in the state where the patient is located.<sup>53</sup> Most states have exceptions to this requirement, applicable only in certain limited circumstances, which include:<sup>54</sup>

- Physician-to-physician consultations (not between practitioner and patient);
- Educational purposes;
- Residency training;
- U.S. Military;
- Public health services; and
- Medical emergencies (Good Samaritan) or natural disasters.

Additionally, a special telehealth license or certificate, which allows an out-of-state licensed health care professional to provide health care services through telehealth to patients located within that particular state, is currently offered in 7 states.<sup>55</sup> Two of these states (Tennessee and Texas), however, only offer the telehealth license to board eligible or board certified specialists.

In the absence of an exception or a state regulation authorizing otherwise, it appears that a health care professional will have to be licensed in the state where the patient is located to provide health care services through telehealth. Requiring health care professionals to obtain multiple state licenses to

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<sup>49</sup> This includes Florida.

<sup>50</sup> *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015. Even amongst states with telehealth statutory regulations, no two states regulate telehealth in exactly the same manner.

<sup>51</sup> *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.* This includes Florida.

<sup>54</sup> *Licensure and Scope of Practice FAQs*, Telehealth Resource Centers, <http://www.telehealthresourcecenter.org/toolbox-module/licensure-and-scope-of-practice#what-are-the-exceptions-to-state-licensure-require> (last visited on January 5, 2016).

<sup>55</sup> *State Telehealth Laws and Reimbursement Policies*, Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015. These states are AL, LA, MN, NM, OH, TN and TX. Additionally, six states (HI, MD, MS, OR, PA and WA) provide exceptions to their state licensure requirements under limited circumstances, i.e. only for radiology or only for border states, or were not telehealth specific exceptions.

provide health care services through telehealth may be burdensome and may inhibit the use of telehealth across state borders.

### *Location Restrictions*

Generally, there are essentially two types of location restrictions. The first restricts the use of telehealth to certain designated areas within a state. For example, only individuals in areas designated as a rural area or a medically underserved area may be authorized to receive health care services through telehealth.

The second restriction relates to limitations on the specific location where telehealth services may be provided. The most common example of this type of limitation is the hub and spoke model.<sup>56</sup> Under this model, “hub” refers to the location to where the health care professional must be located while “spoke” refers to the location where the patient must be located.

The two types of restrictions are not mutually exclusive and are commonly used in conjunction. This presents a significant obstacle to access to care by placing arbitrary restrictions on the use of telehealth which inhibits the effectiveness, as well as the use of telehealth to deliver health care services.

### Telehealth in Florida

Florida does not have a statutory structure for the delivery of health care services through telehealth. The only two references to telehealth in the Florida Statutes are contained within s. 364.0135, F.S. and s. 381.885, F.S. Section 364.0135, F.S., relates to the promotion of broadband internet services by telecommunication companies and does not define or regulate telehealth in any manner. Section 381.885, F.S., is related to epinephrine auto-injectors and expressly states that consultation for the use of the auto-injector through electronic means does not constitute the practice of telemedicine. Further, the only references to telehealth in the Florida Administrative Code relate to the Board of Medicine, Board of Osteopathic Medicine, and the Child Protection Team Program. The Florida Medicaid program also outlines certain requirements relating to telehealth coverage in its rules.<sup>57</sup>

### *Florida Board of Medicine*

In 2003, the Florida Board of Medicine (Board) adopted Rule 64B8-9.014, F.A.C., “Standards for Telemedicine Prescribing Practice” (Rule).<sup>58</sup> The Rule sets forth requirements and restrictions for physicians and physician assistants prescribing medications.<sup>59</sup> The Rule also states that telemedicine “shall include, but is not limited to, prescribing legend drugs to patients through the following modes of communication: (a) Internet; (b) Telephone; and (c) Facsimile.”<sup>60</sup> The Rule however fails to fully define telemedicine or regulate its use in any other way. The Board only regulates allopathic physicians, so this rule does not apply to any other profession.<sup>61</sup>

In 2014 the Board adopted a new rule<sup>62</sup> setting forth standards for telemedicine.<sup>63</sup> The new rule defines telemedicine as the practice of medicine by a licensed Florida physician or physician assistant where

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<sup>56</sup> Florida’s Department of Health’s Children’s Medical Services Program (CMS) currently uses the hub and spoke model to provide services via telehealth to children enrolled in the program.

<sup>57</sup> See Agency for Health Care Administration, Florida Medicaid, “Practitioner Services Coverage and Limitations Handbook,” December 2012, pg. 2-119, available at: <http://portal.flmmis.com/FLPublic/HiddenStaticSearchPage/tabid/55/Default.aspx?publicTextSearch=practioners%20services%20handbook> (last visited on January 5, 2016).

<sup>58</sup> The current telemedicine rules and regulations for the Board of Medicine and the Board of Osteopathic Medicine are virtually identical. Rules 64B8-9.014 and 64B15-14.008, F.A.C.

<sup>59</sup> Rule 64B8-9.014, F.A.C.

<sup>60</sup> Id.

<sup>61</sup> The Board of Osteopathic Medicine rule only applies to osteopathic physicians.

<sup>62</sup> The Board of Medicine and the Board of Osteopathic Medicine rules for telemedicine are identical.

<sup>63</sup> Rule 64B8-9.0141, F.A.C.

patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications.<sup>64</sup> The definition could be interpreted to limit the use of telemedicine to physicians and physician assistants; however, the Board does not have the authority to regulate other professions.<sup>65</sup> The new rule provides that:<sup>66</sup>

- The standard of care is the same as that required for services provided in person;
- A physician-patient relationship may be established through telemedicine;
- A physician or physician assistant is responsible for the quality and safety of the equipment and used to provide services through telemedicine; and
- The same patient confidentiality and record-keeping requirements applicable to in-person services are applicable to services provided through telemedicine.

The new rule prohibits physicians and physician's assistants from providing treatment recommendations, including issuing a prescription, through telemedicine unless the following has occurred:<sup>67</sup>

- A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed;
- A discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment; and
- Contemporaneous medical records are maintained.

The new rule however prohibits prescribing controlled substances through telemedicine but does not preclude physicians from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to 395, F.S.<sup>68</sup>

#### *Child Protection Teams*

The Child Protection Team (CPT) is a medically directed multi-disciplinary program that works with local Sheriff's offices and the Department of Children and Families in cases of child abuse and neglect to supplement investigative activities.<sup>69</sup> The CPT program within the Children's Medical Services (CMS) program utilizes a telehealth network to perform child assessments. The use of telemedicine<sup>70</sup> under this program requires the presence of a CMS approved physician or advanced registered nurse practitioner at the hub site and a registered nurse at the remote site to facilitate the evaluation.<sup>71</sup> In 2014, CPT telehealth services were available at 9 sites and 667 children were provided medical or other assessments via telehealth technology.<sup>72</sup>

#### *Florida Emergency Trauma Telemedicine Network*

Various designated trauma centers participate in the Florida Emergency Trauma Telemedicine Network (FETTN). Coordinated by the Department of Health (DOH), the FETTN facilitates the treatment of trauma patients between trauma centers and community or rural hospitals.<sup>73</sup> The FETTN allows for

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<sup>64</sup> Rule 64B8-9.0141, F.A.C.

<sup>65</sup> The Board of Osteopathic Medicine definition only applies to osteopathic physicians.

<sup>66</sup> See footnote 68 *supra*.

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> Florida Department of Health, *Child Protection Teams*, [http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child\\_protection\\_safety/child\\_protection\\_teams.html](http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html) (last visited January 5, 2016)

<sup>70</sup> Rule 64C-8.001(5), F.A.C., defines telemedicine as "the use of telecommunication and information technology to provide clinical care to individuals at a distance and to transmit the information needed to provide that care."

<sup>71</sup> Rule 64C-8.003(3), F.A.C.

<sup>72</sup> Florida Department of Health, *Maternal and Child Health Block Grant Narrative for 2014*, <http://www.floridahealth.gov/healthy-people-and-families/womens-health/pregnancy/mch-fl-2013-1narrative.pdf> p.21, (last visited: January 5, 2016).

<sup>73</sup> Florida Department of Health, 2014 Agency Legislative Bill Analysis of HB 167, on file with the Florida House of Representative's Select Committee on Health Care Workforce Innovation (October 21, 2013).

multiple interface options and currently 7 out of 25 trauma centers are part of the network.<sup>74</sup> In 2011-12, the seven Level 1 or Level 2 trauma centers that participated as a hub site, known as the location where the consulting physician is delivering the services, were Holmes Regional Medical Center, Tallahassee Memorial Hospital, Sacred Heart Hospital, University of Miami, Shands-Gainesville, Shands-Jacksonville, and Orlando Health.<sup>75</sup>

#### *Other Department of Health Initiatives*

The DOH utilizes tele-radiology through the Tuberculosis Physician's Network.<sup>76</sup> The ability to read electronic chest X-Rays remotely can lead to a faster diagnosis, treatment and a reduction in the spread of the disease, according to DOH. This service is not currently reimbursed by Medicaid.

#### *Florida Medicaid Program*

Under the Medicaid Medical Assistance (MMA) Program implemented in 2014, the vast majority of Medicaid recipients are covered through managed care. Medicaid MMA contracts contain broader allowance for telehealth.<sup>77</sup> Not only may plans use telehealth for behavioral health, dental, and physician services as before but, upon approval by AHCA, may also use telehealth to provide other covered services.<sup>78</sup> The new contract additionally eliminates numerous prior restrictions related to types of services and the type of providers who may utilize telehealth but retains the hub and spoke model.<sup>79</sup>

### **Effect of Proposed Changes**

The bill creates s. 456.47, F.S., relating to the use of telehealth to provide health care services.

"Telehealth" is defined in the bill to mean the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services including, but not limited to, patient assessment, diagnosis, consultation and treatment, monitoring transfer of medical data, patient and professional health-related education, public health services and health administration. The definition of telehealth does not include audio-only telephone calls, e-mail messages or facsimile transmissions. Thus, health care professionals can use telehealth to provide services to patients through both "live" and "store and forward" methods. It also authorizes the use of telemonitoring. The definition does not place any additional limitations on the type of technology that can be used in telehealth. However, both HIPAA and HITECH continue to apply to covered entities.

#### *Telehealth Providers*

The bill defines "telehealth provider" as any person who provides health care related services using telehealth and who is licensed in Florida or is an out-of-state health care registered and is in compliance with the requirements of this bill. Florida licensed telehealth providers must be one of the following professionals.<sup>80</sup>

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<sup>74</sup> Id.

<sup>75</sup> Florida Department of Health, *Long Range Program Plan* (September 28, 2012).

<sup>76</sup> Florida Department of Health, *supra* note 75.

<sup>77</sup> In Florida's Medicaid program the state reimburses physicians on a fee-for-service basis for health care services provided through telemedicine. The use of telemedicine to provide these services is limited to the hospital outpatient setting, inpatient setting, and physician office.

<sup>78</sup> Model Agreement, Attachment II, Exhibit II A, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, November 2015, available at [http://ahca.myflorida.com/Medicaid/statewide\\_mc/plans.shtml](http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml) (last viewed January 5, 2016).

<sup>79</sup> Id.

<sup>80</sup> These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part III, part IV, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

- Behavior analyst;
- Acupuncturist;
- Allopathic physician;
- Osteopathic physician;
- Chiropractor;
- Podiatrist;
- Optometrist;
- Nurse;
- Pharmacist;
- Dentist;
- Dental Hygienist;
- Midwife;
- Speech therapist;
- Occupational therapist;
- Radiology technician;
- Electrologist;
- Orthotist;
- Podiatrist;
- Prosthetist;
- Medical physicist;
- Emergency Medical Technician;
- Paramedic;
- Massage therapist;
- Optician;
- Hearing aid specialist;
- Clinical laboratory personnel;
- Respiratory therapist;
- Physical therapist;
- Psychologist;
- Psychotherapist;
- Dietician/Nutritionist;
- Athletic trainer;
- Clinical social worker;
- Marriage and family therapist; or
- Mental health counselor.

Out-of-state telehealth providers must register annually with DOH or the applicable board to provide telehealth services, within the relevant scope of practice established by Florida law and rule, to patients in this state. To register as an out-of-state telehealth provider, the health care professional must:

- Submit an application to DOH;
- Pay a \$150 registration fee;
- Hold an active unencumbered license, consistent with the definition of “telehealth provider” listed above, in a U.S. state or jurisdiction and against whom no disciplinary action has been taken during the five years before submission of the application; and
- Never had his or her license revoked in any U.S. state or jurisdiction.

The bill prohibits an out-of-state telehealth provider from opening an office in Florida and from providing in-person health care services to patients located in Florida.

The bill requires out-of-state telehealth providers to notify the applicable board or DOH of restrictions placed on the health care professional’s license to practice or disciplinary actions taken against the health care practitioner.

The bill authorizes DOH to revoke an out-of-state telehealth provider's registration if the registrant:

- Fails to immediately notify the department of any adverse actions taken against his or her license;
- Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction; or
- Violates any of the requirements for the registration of out-of-state telehealth providers.

The bill requires DOH to publish on its website the name of each registered out-of-state telehealth provider. It must also include the following background information for each registrant:

- Health care occupation;
- Completed health care training and education, including completion dates and any certificates or degrees obtained;
- Out-of-state health care license with license number;
- Florida telehealth provider registration number;
- Specialty;
- Board certification;
- 5 year disciplinary history, including sanctions and board actions; and
- Medical malpractice insurance provider and policy limits, including whether the policy covers claims which arise in this state.

#### *Telehealth Provider Standards*

The bill establishes that the standard of care for telehealth providers is the same as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

Under the bill a telehealth provider is not required to research a patient's medical history or conduct a physical examination of the patient before providing telehealth services to the patient if the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth. The bill also allows the evaluation to be performed using telehealth.

The bill provides that a patient receiving telehealth services may be in any location at the time that the telehealth services are rendered and that a telehealth provider may be in any location when providing telehealth services to a patient.

The bill allows health care providers who are authorized to prescribe a controlled substance to use telehealth to prescribe controlled substances. Telehealth may not be used to prescribe a controlled substance to treat chronic nonmalignant pain, unless ordered by a physician for an inpatient admitted to a facility licensed under ch. 395, F.S., prescribed for a patient receiving hospice services as defined under s. 400.601, F.S., or prescribed for a resident of a nursing home facility as defined under s. 400.021(12), F.S.

The bill requires that a telehealth provider document the telehealth services rendered in the patient's medical records according to the same standard as that required for in-person services. The bill requires that such medical records be kept confidential consistent with ss. 395.3025(4) and 456.057, F.S. Section 456.057, F.S., relates to all licensed health care professionals while s. 395.3025(4), F.S., relates to all health care facilities licensed under ch. 395 (hospitals, ambulatory surgical centers, and mobile surgical centers). Thus, the same confidentiality requirements placed upon health care facilities

and health care practitioners for medical records generated as part of in-person treatment apply to any medical records generated as part of treatment rendered through telehealth.

The bill provides that a non-physician telehealth provider using telehealth and acting within the applicable scope of practice, as established under Florida law, may not be interpreted as practicing medicine without a license.

The bill establishes, for jurisdictional purposes, that any act that constitutes the delivery of health care services shall be deemed to occur at the place where the patient is located at the time the act is performed. This will assist a patient in establishing jurisdiction and venue in Florida in the event he or she pursues a legal action against the telehealth provider.

The bill provides exceptions to the registration requirement for emergencies or physician to physician consultations.

The bill requires out-of-state pharmacists who are registered telehealth providers to use a permitted Florida pharmacy or a registered nonresident pharmacy to dispense medicinal drugs to Florida patients.

The bill authorizes DOH or an applicable board to adopt rules to administer the requirements set forth in the bill.

#### *Telehealth Survey*

The bill requires AHCA, DOH and OIR, within existing resources, to survey health care facilities, health maintenance organizations, health care practitioners, and health insurers to determine:

- National and state utilization of telehealth;
- Types of health care services provided via telehealth;
- Costs and cost savings associated with using telehealth to provide health care services; and
- Insurance coverage for providing health care services via telehealth.

The bill authorizes AHCA, DOH and OIR to assess fines to enforce participation and completion of the surveys.

The bill requires DOH and OIR to submit their findings and research to AHCA. AHCA is required to submit a report to the Governor, the President of the Senate and the Speaker of the House of Representatives on telehealth utilization and insurance coverage by June 30, 2018.

The bill provides an effective date of July 1, 2016.

#### B. SECTION DIRECTORY:

**Section 1:** Creates s. 456.47, F.S., relating to the use of telehealth to provide services.

**Section 2:** Requires AHCA to report on telehealth utilization and insurance coverage.

**Section 3:** Provides an effective date of July 1, 2016.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

#### A. FISCAL IMPACT ON STATE GOVERNMENT:

##### 1. Revenues:

The bill gives DOH the authority to assess a \$150 registration fee for all out-of-state telehealth providers. The revenue generated is anticipated to be \$769,182 annually assuming that active licensees who would register as out of state telehealth providers compared to the total active in-state physicians in Florida would be comparable to the state of Texas' model. Utilizing the

experience of the Texas Medical Board of a 0.58% rate would generate 5,128 Florida telehealth licenses.<sup>81</sup>

2. Expenditures:

The bill requires all out of state health care professionals to register with the DOH prior to providing any health care services through telehealth to individuals located in Florida. The state of Texas offers a comparable telehealth license to physicians and physicians assistants out of state. There are currently 416 active telehealth licensed physicians in the state of Texas and a total 71,935 active in-state physicians licensed.<sup>82</sup> Applying the ratio found in Texas of telehealth physicians compared to the total in-state physicians of 0.58% to the current active in-state physicians in the state of Florida, 66,468, an anticipated 384 practitioners will seek telehealth licensure in Florida. Applying the same rate to the 820,248 additional medical professionals identified in the bill an anticipated 4,743 will seek licensure as out of state telehealth providers in Florida.<sup>83</sup>

The Florida Medical Quality Assurance Division currently employs 570 positions to regulate 886,716 active in-state licenses. The increase of an anticipated 5,128 licenses would require an additional four full time equivalent positions, 145,870 in salary rate, and \$261,389 recurring and \$15,528 nonrecurring commensurate salary and benefits Medical Quality Assurance Trust Fund budget authority to support these positions. These costs would be offset by the additional revenue generated from the bill's \$150 registration fee.

The bill also requires AHCA, DOH and OIR to conduct a survey on various telehealth and insurance issues, and requires AHCA to compile and prepare the report for the Governor and the Legislature. The DOH anticipates the cost to perform this survey is estimated to be \$334,387 to mail surveys to active in-state licensees identified in the bill. OIR and AHCA will be able to conduct the survey within existing resources.<sup>84</sup> The bill requires the survey costs to be accomplished within existing agency resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

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<sup>81</sup> Physician Statistics, Physicians In and Out of State Report, Texas Medical Board, September 2015, available at <http://www.tmb.state.tx.us/showdoc/statistics> (last viewed February 4, 2016).

<sup>82</sup> Id.

<sup>83</sup> Florida Department of Health, *Annual Report and Long-Range Plan*, Division of Medical Quality Assurance, Fiscal Year 2014-2015, available at <http://mqawebteam.com/annualreports/1415/> Table 15: Revenue, Expenditures and Cash Balances (last viewed February 4, 2016).

<sup>84</sup> Florida Department of Health, 2016 Agency Legislative Bill Analysis of HB 7087, on file with the Florida House of Representative Health Care Appropriations Subcommittee (January 26, 2016).

### **III. COMMENTS**

#### **A. CONSTITUTIONAL ISSUES:**

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

#### **B. RULE-MAKING AUTHORITY:**

The bill authorizes DOH or an applicable board to adopt rules to administer the requirements set forth in the bill.

#### **C. DRAFTING ISSUES OR OTHER COMMENTS:**

None.

### **IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

1                                   A bill to be entitled  
 2           An act relating to telehealth; creating s. 456.47,  
 3           F.S.; providing definitions; establishing certain  
 4           practice standards for telehealth providers; providing  
 5           for the maintenance and confidentiality of medical  
 6           records; providing registration requirements for out-  
 7           of-state telehealth providers; providing limitations  
 8           and notification requirements for out-of-state  
 9           telehealth providers; requiring the Department of  
 10          Health to publish certain information on its website;  
 11          providing for the department to revoke a telehealth  
 12          provider's registration under certain circumstances;  
 13          providing venue; providing exemptions to the  
 14          registration requirement; providing rulemaking  
 15          authority; requiring the Agency for Health Care  
 16          Administration, the Department of Health, and the  
 17          Office of Insurance Regulation to collect certain  
 18          information; requiring the agency to report such  
 19          information to the Governor and Legislature by a  
 20          specified date; providing certain enforcement  
 21          authority to each agency; providing for expiration of  
 22          the reporting requirement; providing an effective  
 23          date.

24  
 25    Be It Enacted by the Legislature of the State of Florida:  
 26

27 Section 1. Section 456.47, Florida Statutes, is created to  
 28 read:

29 456.47 Use of telehealth to provide services.-

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

31 (a) "Telehealth" means the use of synchronous or  
 32 asynchronous telecommunications technology by a telehealth  
 33 provider to provide health care services, including, but not  
 34 limited to, patient assessment, diagnosis, consultation,  
 35 treatment, and monitoring; transfer of medical data; patient and  
 36 professional health-related education; public health services;  
 37 and health administration. The term does not include audio-only  
 38 telephone calls, e-mail messages, or facsimile transmissions.

39 (b) "Telehealth provider" means any individual who  
 40 provides health care and related services using telehealth and  
 41 who is licensed under s. 393.17; part III of chapter 401;  
 42 chapter 457; chapter 458; chapter 459; chapter 460; chapter 461;  
 43 chapter 463; chapter 464; chapter 465; chapter 466; chapter 467;  
 44 part I, part III, part IV, part V, part X, part XIII, or part  
 45 XIV of chapter 468; chapter 478; chapter 480; part III of  
 46 chapter 483; chapter 484; chapter 486; chapter 490; or chapter  
 47 491; or who is registered under and complies with subsection  
 48 (4).

49 (2) PRACTICE STANDARD.-

50 (a) The standard of care for telehealth providers who  
 51 provide health care services is the same as the standard of care  
 52 for health care professionals who provide in-person health care

53 services to patients in this state. If the telehealth provider  
 54 conducts a patient evaluation sufficient to diagnose and treat  
 55 the patient, the telehealth provider is not required to research  
 56 a patient's medical history or conduct a physical examination of  
 57 the patient before using telehealth to provide services to the  
 58 patient. The evaluation may be performed using telehealth.

59 (b) A telehealth provider may not use telehealth to  
 60 prescribe a controlled substance to treat chronic nonmalignant  
 61 pain, as defined under s. 456.44, unless the controlled  
 62 substance is ordered for inpatient treatment at a hospital  
 63 licensed under chapter 395, is prescribed for a patient  
 64 receiving hospice services, as defined under s. 400.601, or is  
 65 prescribed for a resident of a nursing home facility as defined  
 66 under s. 400.021(12).

67 (c) A telehealth provider and a patient may each be in any  
 68 location when telehealth is used to provide health care services  
 69 to a patient.

70 (d) A nonphysician telehealth provider using telehealth  
 71 and acting within the relevant scope of practice, as established  
 72 by Florida law and rule, is not a violation of s. 458.327(1)(a)  
 73 or s. 459.013(1)(a).

74 (3) RECORDS.—A telehealth provider shall document in the  
 75 patient's medical record the health care services rendered using  
 76 telehealth according to the same standard as used for in-person  
 77 services. Medical records, including video, audio, electronic,  
 78 or other records generated as a result of providing such

79 services, are confidential pursuant to ss. 395.3025(4) and  
 80 456.057.

81 (4) REGISTRATION OF OUT-OF-STATE TELEHEALTH PROVIDERS.—

82 (a) A health care professional not licensed in this state  
 83 may provide health care services to a patient located in this  
 84 state using telehealth if the telehealth provider annually  
 85 registers with the applicable board, or the department if there  
 86 is no board, and provides health care services within the  
 87 relevant scope of practice established by Florida law or rule.

88 (b) The board, or the department if there is no board,  
 89 shall register a health care professional not licensed in this  
 90 state as a telehealth provider if the health care professional:

- 91 1. Completes an application in the format prescribed by
- 92 the department;
- 93 2. Pays a \$150 registration fee; and
- 94 3. Holds an active, unencumbered license for a profession
- 95 listed in paragraph (1)(b) which is issued by another state, the
- 96 District of Columbia, or a possession or territory of the United
- 97 States and against whom no disciplinary action has been taken
- 98 during the 5 years before submission of the application. The
- 99 department shall use the National Practitioner Data Bank to
- 100 verify information submitted by an applicant.

101 (c) A health care professional may not register under this  
 102 subsection if his or her license to provide health care services  
 103 is subject to a pending disciplinary investigation or action, or  
 104 has been revoked in any state or jurisdiction. A health care

105 professional registered under this section must immediately  
 106 notify the appropriate board, or the department if there is no  
 107 board, of restrictions placed on the health care professional's  
 108 license to practice, or disciplinary action taken or pending  
 109 against the health care professional, in any state or  
 110 jurisdiction.

111 (d) A health care professional registered under this  
 112 subsection may not open an office in this state and may not  
 113 provide in-person health care services to patients located in  
 114 this state.

115 (e) A pharmacist registered under this subsection may only  
 116 use a pharmacy permitted under chapter 465, or a nonresident  
 117 pharmacy registered under s. 465.0156, to dispense medicinal  
 118 drugs to patients located in this state.

119 (f) The department shall publish on its website a list of  
 120 all registrants and include, to the extent applicable, each  
 121 registrant's:

- 122 1. Name.
- 123 2. Health care occupation.
- 124 3. Completed health care training and education, including  
 125 completion dates and any certificates or degrees obtained.
- 126 4. Out-of-state health care license with license number.
- 127 5. Florida telehealth provider registration number.
- 128 6. Specialty.
- 129 7. Board certification.
- 130 8. Five-year disciplinary history, including sanctions and

131 board actions.

132 9. Medical malpractice insurance provider and policy  
 133 limits, including whether the policy covers claims which arise  
 134 in this state.

135 (g) The department may revoke an out-of-state telehealth  
 136 provider's registration if the registrant:

137 1. Fails to immediately notify the department of any  
 138 adverse actions taken against his or her license as required  
 139 under paragraph (c).

140 2. Has restrictions placed on or disciplinary action taken  
 141 against his or her license in any state or jurisdiction.

142 3 . Violates any of the requirements of this section.

143 (5) VENUE.-For the purposes of this section, any act that  
 144 constitutes the delivery of health care services is deemed to  
 145 occur at the place where the patient is located at the time the  
 146 act is performed.

147 (6) EXEMPTIONS.-A health care professional who is not  
 148 licensed to provide health care services in this state but who  
 149 holds an active license to provide health care services in  
 150 another state or jurisdiction, and who provides health care  
 151 services using telehealth to a patient located in this state, is  
 152 not subject to the registration requirement under this section  
 153 if the services are provided:

154 (a) In response to an emergency medical condition as  
 155 defined in s. 395.002; or

156 (b) In consultation with a health care professional

157 | licensed in this state and that health care professional retains  
 158 | ultimate authority over the diagnosis and care of the patient.

159 | (7) RULEMAKING.—The applicable board, or the department if  
 160 | there is no board, may adopt rules to administer this section.

161 | Section 2. Telehealth utilization and insurance coverage  
 162 | report.—

163 | (1) The Agency for Health Care Administration, the  
 164 | Department of Health, and the Office of Insurance Regulation  
 165 | shall, within existing resources, survey health care facilities,  
 166 | health maintenance organizations, health care practitioners, and  
 167 | health insurers, respectively, and perform any other research  
 168 | necessary to collect the following information:

169 | (a) The types of health care services provided via  
 170 | telehealth.

171 | (b) The extent to which telehealth is used by health care  
 172 | practitioners and health care facilities nationally and in the  
 173 | state.

174 | (c) The estimated costs and cost savings to health care  
 175 | entities, health care practitioners, and the state associated  
 176 | with using telehealth to provide health care services.

177 | (d) Which health care insurers, health maintenance  
 178 | organizations, and managed care organizations cover health care  
 179 | services provided to patients in Florida via telehealth, whether  
 180 | the coverage is restricted or limited, and how such coverage  
 181 | compares to that insurer's coverage for services provided in  
 182 | person. The comparison shall at a minimum include:

- 183        1. Covered medical or other health care services.
- 184        2. A description of whether payment rates for such  
 185 services provided via telehealth are less than, equal to, or  
 186 greater than payment rates for such services provided in person.
- 187        3. Any annual or lifetime dollar maximums on coverage for  
 188 services provided via telehealth and in person.
- 189        4. Any copayments, coinsurance, or deductible amounts, or  
 190 policy year, calendar year, lifetime, or other durational  
 191 benefit limitation or maximum for benefits or services provided  
 192 via telehealth and in person.
- 193        5. Any conditions imposed for coverage for services  
 194 provided via telehealth that are not imposed for coverage for  
 195 the same services provided in person.
- 196        (e) The barriers to using, implementing the use of, or  
 197 accessing services via telehealth.
- 198        (2) The Agency for Health Care Administration shall  
 199 compile the surveys and research findings required by this  
 200 section and submit a report to the Governor, the President of  
 201 the Senate, and the Speaker of the House of Representatives by  
 202 June 30, 2018.
- 203        (3) The Department of Health and the Office of Insurance  
 204 Regulation shall submit their survey and research findings to  
 205 the agency and shall assist the agency in compiling the  
 206 information to prepare the report.
- 207        (4) The Agency for Health Care Administration, the  
 208 Department of Health, and the Office of Insurance Regulation may

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209 assess fines under s. 408.813(2)(d), s. 456.072(2)(d), and s.  
210 624.310(5), respectively, against a health care facility, health  
211 maintenance organization, health care practitioner, and health  
212 insurer for failure to complete the surveys required under this  
213 section.

214 (5) This section expires July 1, 2018.

215 Section 3. This act shall take effect July 1, 2016.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___	(Y/N)
ADOPTED AS AMENDED	___	(Y/N)
ADOPTED W/O OBJECTION	___	(Y/N)
FAILED TO ADOPT	___	(Y/N)
WITHDRAWN	___	(Y/N)
OTHER	_____	

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1 Committee/Subcommittee hearing bill: Health Care Appropriations  
2 Subcommittee  
3 Representative Sprowls offered the following:

**Amendment**

Remove line 203 and insert:

7 (3) The Department of Health shall survey all health care  
8 practitioners, as defined under s. 456.001, upon and as a  
9 condition of licensure renewal to compile the information  
10 required pursuant to this section. The Department of Health and  
11 the Office of Insurance

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___	(Y/N)
ADOPTED AS AMENDED	___	(Y/N)
ADOPTED W/O OBJECTION	___	(Y/N)
FAILED TO ADOPT	___	(Y/N)
WITHDRAWN	___	(Y/N)
OTHER	_____	

1 Committee/Subcommittee hearing bill: Health Care Appropriations  
2 Subcommittee

3 Representative Sprowls offered the following:

4  
5 **Amendment (with title amendment)**

6 Between lines 214 and 215, insert:

7 Section 3. For the 2016-2017 fiscal year, 4 full-time equivalent  
8 positions, with associated salary rate of 145,870 are authorized  
9 and the sums of \$261,389 in recurring funds and \$15,528 in  
10 nonrecurring funds from the Medical Quality Assurance Trust Fund  
11 are hereby appropriated to the Department of Health for the  
12 purpose of implementing the requirements of the act.

13  
14 -----  
15 **T I T L E A M E N D M E N T**

16 Remove lines 22-23 and insert:

Amendment No. 2

17 | the reporting requirement; providing an appropriation; providing  
18 | an effective date.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7097      PCB CFSS 16-01      Mental Health and Substance Abuse  
**SPONSOR(S):** Children, Families & Seniors Subcommittee, Harrell  
**TIED BILLS:**            **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	11 Y, 0 N	McElroy	Brazzell
1) Health Care Appropriations Subcommittee		Fontaine <i>WJA</i>	Pridgeon <i>JP</i>
2) Health & Human Services Committee			

### SUMMARY ANALYSIS

HB 7079 makes changes to the statewide system of safety-net prevention, treatment, and recovery services for substance abuse and mental health (SAMH) administered by the Department of Children and Families (DCF). DCF currently contracts with seven managing entities that in turn contract with local service providers to deliver SAMH services. The bill updates statutes that provided DCF initial authority and guidance for transitioning to the managing entity system. The bill makes changes regarding service provision and enhances operation of this outsourced approach by:

- Allowing managed behavioral health organizations to bid for managing entity contracts when fewer than two bids are received;
- Requiring managing entities to earn coordinated behavioral health system of care designation by 2019 and requiring the annual submission of plans for phased enhancement of the subsystems within their system of care, including specific information on recommendations for additional funding;
- Requiring managing entities to provide care coordination, specifying services that shall be provided within available resources, and prioritizing the populations served;
- Requiring DCF to develop performance standards that measure improvement in a community's behavioral health and in specified individuals' functioning or progress toward recovery;
- Specifying members for managing entities' governing boards, and requiring managed behavioral health organizations serving as managing entities to have advisory boards with that membership;
- Allowing managing entities flexibility in shaping their provider network while requiring a system for publicizing opportunities to join and evaluating providers for participation; and
- Deleting obsolete statutes regarding the transition to the managing entity system.

The bill revises the Criminal Justice, Mental Health, and Substance Abuse Grant Program. The bill expands the membership of the Statewide Grant Review Committee to include more non-state representatives and renames it the Policy Committee. The bill creates a grant review and selection committee. It also streamlines the local process for applying for grants and allows DCF to require sequential intercept mapping of systems to identify where interventions may be effective.

The bill revises the Marchman Act, which provides for voluntary and involuntary treatment for substance abuse impairment, by:

- Requiring DCF to develop, adopt and publish standard forms for Marchman Act pleadings and reporting;
- Requiring DCF to create a statewide database for collecting utilization data for all Marchman Act initiated detoxification unit and addictions receiving facility services funded by DCF;
- Requiring law enforcement to execute a DCF-created Marchman Act form when initiating protective custody, unless the individual is being taken to jail;
- Prohibiting courts from charging a filing fee for petitions;
- Allowing the court to grant a continuance for the hearing on the petition for involuntary treatment; and
- Allowing the respondent, or an individual on the respondent's behalf, to pay for court ordered involuntary treatment.

The bill repeals a variety of obsolete statutes.

The bill has a significant fiscal impact to DCF of \$400,000 for the creation of the statewide Marchman Act database.

The bill provides an effective date of July 1, 2016, except as otherwise provided in the act.

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### Current Situation

##### Mental Illness and Substance Abuse

Mental health and mental illness are not synonymous. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.<sup>1</sup> The primary indicators used to evaluate an individual's mental health are:<sup>2</sup>

- **Emotional well-being-** Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being-** Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being-** Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.<sup>3</sup> Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. Only about 17% of adults in the United States are considered to be in a state of optimal mental health.<sup>4</sup> This leaves the majority of the population with less than optimal mental health, for example:<sup>5</sup>

- One in four adults (61.5 million people) experiences mental illness in a given year;
- Approximately 6.7 percent (14.8 million people) live with major depression; and
- Approximately 18.1 percent (42 million people) live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder and phobias.

Many people are diagnosed with more than one mental illness. For example, people who suffer from a depressive illness (major depression, bipolar disorder, or dysthymia) often have a co-occurring mental illness such as anxiety.<sup>6</sup>

<sup>1</sup> *Mental Health Basics*, Centers for Disease Control and Prevention. <http://www.cdc.gov/mentalhealth/basics.htm> (last viewed on January 4, 2016).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> *Id.* Mental illness can range in severity from no or mild impairment to significantly disabling impairment. Serious mental illness is a mental disorder that has resulted in a functional impairment which substantially interferes with or limits one or more major life activities. *Any Mental Illness (AMI) Among Adults*, National Institute of Mental Health. <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml> (last viewed on January 4, 2016).

<sup>5</sup> *Mental Illness Facts and Numbers*, National Alliance on Mental Illness. [http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&sqi=2&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.nami.org%2Ffactsheets%2Fmentalillness\\_factsheet.pdf&ei=dYMIVdrWOYmqgwTBIYDQDA&usq=AFQjCNEATQZ5TXJF063JkMNqg9Zn wZb\\_ZA&bvm=bv.88198703,d.eXY](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&sqi=2&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.nami.org%2Ffactsheets%2Fmentalillness_factsheet.pdf&ei=dYMIVdrWOYmqgwTBIYDQDA&usq=AFQjCNEATQZ5TXJF063JkMNqg9Zn wZb_ZA&bvm=bv.88198703,d.eXY) (last viewed on January 4, 2016).

<sup>6</sup> *Mental Health Disorder Statistics*, John Hopkins Medicine. [http://www.hopkinsmedicine.org/healthlibrary/conditions/mental\\_health\\_disorders/mental\\_health\\_disorder\\_statistics\\_85.P00753/](http://www.hopkinsmedicine.org/healthlibrary/conditions/mental_health_disorders/mental_health_disorder_statistics_85.P00753/) (last viewed on January 4, 2016).

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.<sup>7</sup> In 2013, an estimated 21.6 million persons aged 12 or older were classified with having substance dependence or abuse issues.<sup>8</sup> Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 4.3 million had dependence or abuse of illicit drugs but not alcohol, and 14.7 million had dependence or abuse of alcohol but not illicit drugs.<sup>9</sup>

Significant social and economic costs are associated with mental illness. Persons diagnosed with a serious mental illness experience significantly higher rates of unemployment compared with the general population.<sup>10</sup> This results in substantial loss of earnings each year<sup>11</sup> and can lead to homelessness. Homelessness is especially high for people with untreated serious mental illness, who comprise approximately one-third of the total homeless population.<sup>12</sup> Both adults and youth with mental illness frequently interact with the criminal justice system, which can lead to incarceration. For example, seventy percent of youth in juvenile justice systems have at least one mental health condition and at least twenty percent live with a severe mental illness.<sup>13</sup>

Substance abuse likewise has substantial economic and societal costs. In 2004, the total estimated costs of drug abuse and addiction due to use of tobacco, alcohol and illegal drugs was estimated at \$524 billion a year.<sup>14</sup> This consists of \$181 billion/year related to illegal drugs, \$185 billion/year related to alcohol and \$193 billion/year related to tobacco use.<sup>15</sup> These figures assume costs related to health care expenditures, lost earnings, law enforcement and incarceration.<sup>16</sup>

Mental illness and substance abuse commonly co-occur. Approximately 8.9 million adults have co-occurring disorders.<sup>17</sup> In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).<sup>18</sup> Drug abuse can cause individuals to experience one or more symptoms of another mental illness.<sup>19</sup> Additionally, individuals with mental illness may abuse drugs as a form of self-medication.<sup>20</sup> Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol

<sup>7</sup> *Substance Abuse*, World Health Organization. [http://www.who.int/topics/substance\\_abuse/en/](http://www.who.int/topics/substance_abuse/en/) (last viewed on January 4, 2016).

<sup>8</sup> Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.samhsa.gov%2Fdata%2Fsites%2Fdefault%2Ffiles%2FNSDUHresultsPDFWHTML2013%2FWeb%2FNSDUHresults2013.pdf&ei=L74IVzdKO2SsQStroDQCg&usq=AFQjCNE8sNFxhZQfOgdkJvOgZR3fP5I0Uw> (last viewed on January 4, 2016).

<sup>9</sup> *Id.*

<sup>10</sup> *Accounting for Unemployment Among People with Mental Illness*, Baron RC, Salzer MS, *Behav. Sci. Law.*, 2002;20(6):585-99. <http://www.ncbi.nlm.nih.gov/pubmed/12465129> (last viewed on January 4, 2016).

<sup>11</sup> *Supra* footnote 5.

<sup>12</sup> *How Many Individuals with A Serious Mental Illness are Homeless?* Treatment Advocacy Center, Backgrounder, November 2014. <http://www.treatmentadvocacycenter.org/problem/consequences-of-non-treatment/2058> (last viewed on January 4, 2016).

<sup>13</sup> *Supra* footnote 5.

<sup>14</sup> *Drug Abuse Costs The United States Economy Hundreds of billions of Dollars in Increased Health Care Costs, Crime and Lost Productivity*, National Institute on Drug Abuse, July 2008. <http://www.drugabuse.gov/publications/addiction-science-molecules-to-managed-care/introduction/drug-abuse-costs-united-states-economy-hundreds-billions-dollars-in-increased-health> (last viewed on January 4, 2016).

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> *About Co-Occurring, Substance Abuse and Mental Health Services Administration.* <http://media.samhsa.gov/co-occurring/default.aspx> (last viewed on January 4, 2016).

<sup>18</sup> *Co-Occurring Disorders*, Psychology Today. <https://www.psychologytoday.com/conditions/co-occurring-disorders> (last viewed on January 4, 2016).

<sup>19</sup> *Comorbidity: Addiction and Other Mental Illnesses*, U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCMQFjAA&url=http%3A%2F%2Fwww.drugabuse.gov%2Fsites%2Fdefault%2Ffiles%2Frrcomorbidity.pdf&ei=6q8NVF-iMsibNo7gg4AO&usq=AFQjCNFujSP7SHxxqB3FI7961yGQNNQ56YA&bvm=bv.88528373.d.eXY> (last viewed on January 4, 2016).

<sup>20</sup> *Id.*

addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.<sup>21</sup>

### Florida's Substance Abuse and Mental Health Program

The Florida Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.<sup>22</sup>

#### *Behavioral Health Managing Entities*

In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.<sup>23</sup> This was based upon the Legislature's decision that a management structure that places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level would:<sup>24</sup>

- Promote improved access to care;
- Promote service continuity; and
- Provide for more efficient and effective delivery of substance abuse and mental health services.

The implementation of the managing entity system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement managing entities statewide.<sup>25</sup> Full implementation of the statewide managing entity system occurred in April 2013, with all geographic regions now served by a managing entity.<sup>26</sup> Implementation has allowed DCF to reduce the number of direct contracts for mental health and substance abuse services from several hundred to 7.<sup>27</sup> DCF currently contracts with 7 managing entities that in turn contract with local service providers for the delivery of mental health and substance abuse services:<sup>28</sup>

- Big Bend Community Based Care- April 1, 2013 (**blue**).
- Lutheran Services Florida- July 1, 2012 (**yellow**).
- Central Florida Cares Health System- July 1, 2012 (**orange**).
- Central Florida Behavioral Health Network, Inc.- July 1, 2012 (**red**).
- Southeast Florida Behavioral Health- October 1, 2012 (**pink**).
- Broward Behavioral Health Network, Inc.- November 6, 2012 (**purple**).
- South Florida Behavioral Health Network, Inc.- October 1, 2012 (**beige**).

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<sup>21</sup> *Supra* footnote 18.

<sup>22</sup> These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance and children at risk for initiating drug use.

<sup>23</sup> Ch. 2001-191, Laws.

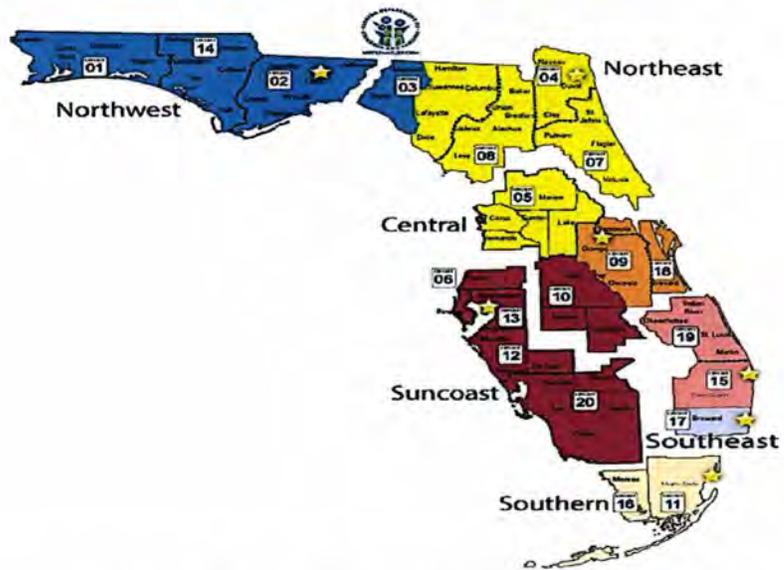
<sup>24</sup> Section 394.9082, F.S.

<sup>25</sup> Chapter 2008-243, Laws.

<sup>26</sup> *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.

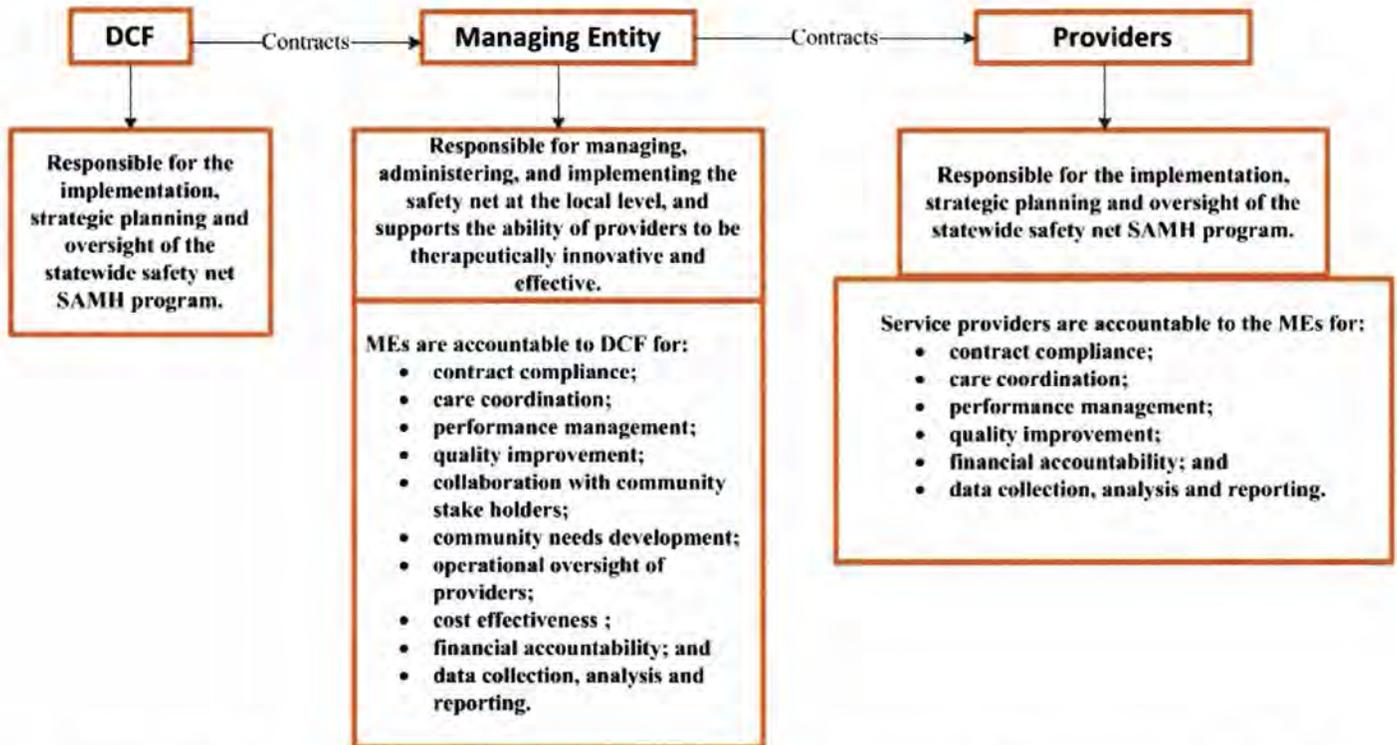
<sup>27</sup> *Department of Children and Families Service System Management Plan, Statewide Implementation of Managing Entities or Similar Model*, July 2009.

<sup>28</sup> *Managing Entities*, Department of Children and Families. <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities> (last viewed on January 4, 2016).



Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.

DCF, managing entities and service providers have specific responsibilities in the SAMH program.



DCF utilizes four performance measures to evaluate the performance of the managing entities:<sup>29</sup>

- **Systemic Monitoring** – The managing entity shall complete on-site monitoring of no less than 20% of all network service providers each fiscal year;
- **Network Service Provider Compliance** – A minimum of 95% of the managing entity’s network service providers shall demonstrate annual compliance with a minimum of 85% of the applicable network service provider measures (i.e., client outcome measures) at the target levels for the network service provider established in the subcontract;
- **Block Grant Implementation** – The managing entity shall ensure 100% of the cumulative annual network service provider expenses comply with the block grant and maintenance of effort establish allocation standards; and
- **Implementation of the General Appropriations Act:** The managing entity shall meet 100% of the following requirements:
  - Implementation of specific appropriations, demonstrated by contracts with network services providers; and
  - Submission of all required plans for federal substance abuse and mental health block grants.

Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program

In 2007, the Legislature created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Program). The purpose of the Program is to provide funding to counties to plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal and juvenile justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental

<sup>29</sup> The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities, Office of Program Policy Analysis & Government Accountability, July 18, 2014.

health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.<sup>30</sup>

Currently, only a county or a consortium of counties who have established planning councils or committees may apply for a grant under the Program.<sup>31</sup> The county may designate an agency, including a non-county agency, as "lead agency;" however, the application must be submitted under the authority of the county.<sup>32</sup> Applicants may seek a one-year planning grant or a three-year implementation or expansion grant.<sup>33</sup> An applicant must have previously received a planning grant to be eligible for an implementation or expansion grant. A grant may not be awarded unless the applicant county, or a consortium of counties, makes available resources in an amount equal to the total amount of the grant.<sup>34</sup>

The Program's Statewide Grant Review Committee (Committee) is responsible for evaluating applications submitted to the Program. The Committee includes:<sup>35</sup>

- One representative of DCF;
- One representative of the Department of Corrections;
- One representative of the Department of Juvenile Justice;
- One representative of the Department of Elderly Affairs; and
- One representative of the Office of the State Courts Administrator.

The Committee provides written notification to DCF of the names of the applicants who have been selected to receive a grant.<sup>36</sup> DCF may then transfer funds, if available, to any counties or consortium of counties awarded a grant.<sup>37</sup> A grant may not be awarded unless the applicant county, or a consortium of counties, makes available resources in an amount equal to the total amount of the grant.<sup>38</sup> For fiscally constrained counties, the available resources may be at 50 percent of the total amount of the grant.<sup>39</sup>

### *Sequential Intercept Model*

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems.<sup>40</sup> The model seeks to identify points of interception where an intervention can occur to prevent an individual from entering or penetrating deeper into the criminal justice system.<sup>41</sup> The interception points are:<sup>42</sup>

- Law enforcement and emergency services;
- Initial detention and initial hearings;
- Jail, courts, forensic evaluations, and forensic commitments;
- Reentry from jails, state prisons, and forensic hospitalization; and
- Community corrections and community support.

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<sup>30</sup> Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant: Request for Applications, Department of Children and Families, May 2013.

<sup>31</sup> Section 394. 658(3), F.S.

<sup>32</sup> Id.

<sup>33</sup> Section 394. 656(3)(a), F.S.

<sup>34</sup> Section 394. 658(2)(b) and (c), F.S.

<sup>35</sup> Section 394. 656(2)(a-e), F.S.

<sup>36</sup> Section 394. 656(4), F.S.

<sup>37</sup> Id.

<sup>38</sup> Section 394. 658(2)(b) and (c), F.S.

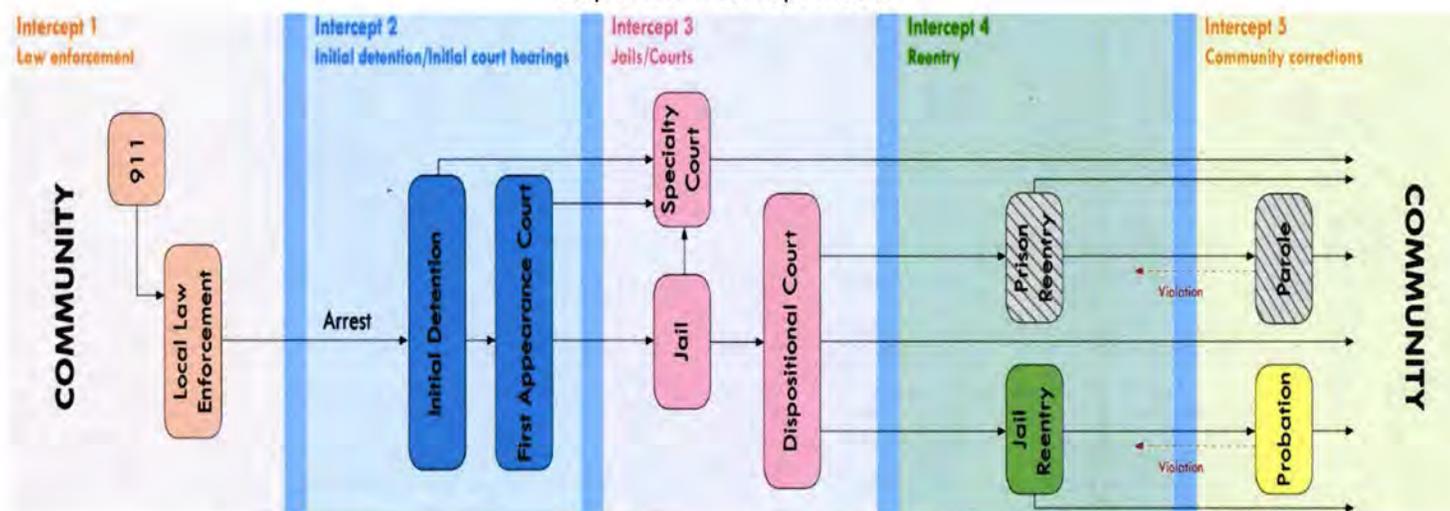
<sup>39</sup> Id.

<sup>40</sup> *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, Munetz MR and Griffin PA, *Psychiatr. Serv.*, 2006 April; 57(4):544-9. <http://www.ncbi.nlm.nih.gov/pubmed/16603751> (last viewed on January 4, 2016).

<sup>41</sup> Id.

<sup>42</sup> Id.

## Sequential Intercept Model



SAMHSA Gain Center for Behavioral Health and Justice Transformation.

A community can use the model to develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment.<sup>43</sup>

### Florida Mental Health Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.<sup>44</sup> The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.<sup>45</sup>

#### *Involuntary Examination and Receiving Facilities*

Individuals in acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.<sup>46</sup> An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness<sup>47</sup>:

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

Involuntary patients must be taken to either a public or a private facility that has been designated by DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold

<sup>43</sup> Id.

<sup>44</sup> Sections 394.451-394.47891, F.S.

<sup>45</sup> Section 394.459, F.S.

<sup>46</sup> Sections 394.4625 and 394.463, F.S.

<sup>47</sup> Section 394.463(1), F.S.

involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment.<sup>48</sup> A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.<sup>49</sup> Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.<sup>50</sup>

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.<sup>51</sup> CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.<sup>52</sup>

The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.<sup>53</sup> Individuals often enter the public mental health system through CSUs.<sup>54</sup> For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.<sup>55</sup>

For FY 2014-15 there are 544 adult and 106 crisis stabilization beds funded by DCF.<sup>56</sup> There were 181,471 involuntary examinations initiated at hospitals and CSUs in calendar year 2014 (most recent report).<sup>57</sup>

#### *Guardian Advocate*

The Baker Act provides for the appointment of a guardian advocate for individuals who are incompetent to consent to treatment. The guardian advocate is responsible for making well-informed mental health treatment decisions for the patient. The administrator of a receiving or treatment facility may petition the court for the appointment of advocate guardian if a psychiatrist has determined that a patient is incompetent to consent to treatment.<sup>58</sup> The court will conduct a hearing on the petition during which a patient will have the right to testify, cross-examine witnesses, and present witnesses.<sup>59</sup> The court will appoint a qualified guardian advocate if it finds the patient incompetent.<sup>60</sup> The court may not appoint certain individuals as a guardian advocate:<sup>61</sup>

- An employee of the facility providing direct mental health services to the patient;
- A DCF employee;
- An administrator of a treatment or receiving facility; or
- A member of the Florida local advocacy council.

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<sup>48</sup> Section 394.455(26), F.S.

<sup>49</sup> Section 394.455(25), F.S.

<sup>50</sup> Rule 65E-5.400(2), F.A.C.

<sup>51</sup> Section 394.875(1)(a), F.S.

<sup>52</sup> Id.

<sup>53</sup> Id.

<sup>54</sup> Budget Subcommittee on Health and Human Services Appropriations, the Florida Senate, Crisis Stabilization Units, (Interim Report 2012-109) (Sept. 2011).

<sup>55</sup> Id. Sections 394.65-394.9085, F.S.

<sup>56</sup> Id.

<sup>57</sup> Christy, A. (2015). Report of 2014 *Baker Act Data*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.

<sup>58</sup> Section 394.4598(1), F.S.

<sup>59</sup> Id.

<sup>60</sup> Id.

<sup>61</sup> Id.

The facility must provide a guardian advocate with sufficient information for a guardian advocate to make an informed decision.<sup>62</sup> This includes information related to whether the proposed treatment is essential to the care of the patient and whether the proposed treatment presents an unreasonable risk of serious, hazardous, or irreversible side effects.<sup>63</sup> A guardian advocate must meet and talk with the patient and the patient's physician in person (if at all possible) before giving consent to treatment.<sup>64</sup> The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.<sup>65</sup>

Guardian advocates may only provide consent for mental health treatment if the patient is incompetent. The appointment of a guardian advocate will be terminated if a patient is:

- Discharged from an order for involuntary outpatient placement or involuntary inpatient placement;
- Transferred from involuntary to voluntary status; or
- Determined by the court to be competent.

### The Marchman Act

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse.<sup>66</sup> The laws resulted in separate funding streams and requirements for alcoholism and drug abuse; in response to the laws, the Florida Legislature enacted Chapters 396, F.S., (alcohol) and 397, F.S. (drug abuse).<sup>67</sup> Each of these laws governed different aspects of addiction, and thus had different rules promulgated by the state to fully implement the respective pieces of legislation.<sup>68</sup> However, because persons with substance abuse issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address the problems faced by Florida's citizens.<sup>69</sup> In 1993 legislation was adopted to combine Chapters 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").<sup>70</sup>

The Marchman Act program is designed to support the prevention and remediation of substance abuse through the provision of a comprehensive system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

#### *Voluntary vs. Involuntary Admissions*

An individual may receive services under the Marchman Act through either a voluntary or an involuntary admission. The Marchman Act encourages persons to seek treatment on a voluntary basis and to be actively involved in planning their own services with the assistance of a qualified professional. An individual who wishes to enter treatment may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.<sup>71</sup> However, denial of addiction is a common symptom, raising a barrier to early intervention

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<sup>62</sup> Section 394.4598(2), F.S.

<sup>63</sup> Id.

<sup>64</sup> Id.

<sup>65</sup> Section 394.4598(7), F.S.

<sup>66</sup> Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5

<sup>67</sup> Id.

<sup>68</sup> Id.

<sup>69</sup> Id.

<sup>70</sup> Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.

<sup>71</sup> S. 397.601(1), F.S. Additionally, under s. 397.601(4)(a), F.S., a minor is authorized to consent to treatment for substance abuse.

and treatment.<sup>72</sup> As a result, treatment often comes because of a third party making the intervention needed for substance abuse services.<sup>73</sup>

The Marchman Act establishes a variety of methods under which substance abuse assessment, stabilization and treatment can be obtained on an involuntary basis. There are five involuntary admission procedures that can be broken down into two categories depending upon whether the court is involved. Regardless of the nature of the proceedings, an individual meets the criteria for an involuntary admission under the Marchman Act when there is good faith reason to believe the individual is substance abuse impaired and, because of such impairment, has lost the power of self-control with respect to substance use; and either has inflicted, attempted or threatened to inflict, or unless admitted, is likely to inflict physical harm on himself/herself or another; or the person's judgment has been so impaired because of substance abuse that he/she is incapable of appreciating the need for substance abuse services and of making a rational decision in regard to substance abuse services.<sup>74</sup>

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

The three types of non-court procedures for involuntary admission for substance abuse treatment under the Marchman Act are:

- **Protective Custody:** Law enforcement officers use this when an individual is substance-impaired or intoxicated in public and is brought to the attention of the officer. The purpose of this procedure is to allow the person to be taken to a safe environment for observation and assessment to determine the need for treatment.<sup>75</sup> Law enforcement is not required to execute a written report for the initiation of protective custody.
- **Emergency Admission:** This permits an individual who appears to meet the criteria for involuntary admission to be admitted to a hospital, an addiction receiving facility or a detoxification facility for emergency assessment and stabilization. Individuals admitted for involuntary assessment and stabilization under this provision must have a physician's certificate for admission, demonstrating the need for this type of placement and recommending the least restrictive type of service that is appropriate to the needs of the individual.<sup>76</sup>
- **Alternative Involuntary Assessment for Minors:** This provides a way for a parent, legal guardian or legal custodian to have a minor admitted to an addiction receiving facility to assess the minor's need for treatment by a qualified professional.<sup>77</sup>

#### *Court Involved Involuntary Admissions*

The two court involved Marchman Act procedures are involuntary assessment and stabilization, which provides for short-term court-ordered substance abuse treatment, and involuntary treatment, which provides for long-term court-ordered substance abuse treatment. Both are initiated through the filing of a petition for which the court may charge a filing fee.

#### *Involuntary Assessment and Stabilization*

Involuntary assessment and stabilization involves filing a petition with the court. The petition for involuntary assessment and stabilization must contain:

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<sup>72</sup> Darran Duchene and Patrick Lane, *Fundamentals of the Marchman Act*, Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Program, <http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/> (last visited December 16, 2015).

<sup>73</sup> Id.

<sup>74</sup> S. 397.675, F.S.

<sup>75</sup> S. 397.667, F.S. A law enforcement officer may take the individual to their residence, to a hospital, a detoxification center, or addiction receiving facility, or in certain circumstances, to jail. Minors, however, cannot be taken to jail.

<sup>76</sup> S. 397.679, F.S.

<sup>77</sup> S. 397.6822, F.S.

- The name of the applicant or applicants (the individual(s) filing the petition with the court);
- The name of the respondent (the individual whom the applicant is seeking to have involuntarily assessed and stabilized);
- The relationship between the respondent and the applicant;
- The name of the respondent's attorney, if he or she has one, and whether the respondent is able to afford an attorney; and
- Facts to support the need for involuntary assessment and stabilization, including the reason for the applicant's belief that:
  - The respondent is substance abuse impaired; and
  - The respondent has lost the power of self-control with respect to substance abuse; and either that
  - The respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
  - The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.<sup>78</sup>

Once the petition is filed with the court, the court issues a summons to the respondent and the court must schedule a hearing to take place within 10 days, or can issue an ex parte order immediately.<sup>79</sup>

After hearing all relevant testimony, the court determines whether the respondent meets the criteria for involuntary assessment and stabilization and must immediately enter an order that either dismisses the petition or authorizes the involuntary assessment and stabilization of the respondent.

If the court determines the respondent meets the criteria, it may order him or her to be admitted for a period of 5 days<sup>80</sup> to a hospital, licensed detoxification facility, or addictions receiving facility, for involuntary assessment and stabilization.<sup>81</sup> During that time, an assessment is completed on the individual.<sup>82</sup> The written assessment is sent to the court. Once the written assessment is received, the court must either

- Release the individual and, if appropriate, refer the individual to another treatment facility or service provider, or to community services;
- Allow the individual to remain voluntarily at the licensed provider; or
- Hold the individual if petition for involuntary treatment has been initiated.<sup>83</sup>

### *Involuntary Treatment*

Involuntary treatment allows the court to require the individual to be admitted for treatment for a longer period only if the individual has previously been involved in at least one of the four other involuntary

<sup>78</sup> S. 397.6814, F.S.

<sup>79</sup> S. 397.6815, F.S. Under the ex parte order, the court may order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him/her to the nearest appropriate licensed service provider

<sup>80</sup> If a licensed service provider is unable to complete the involuntary assessment and, if necessary, stabilization of an individual within 5 days after the court's order, it may, within the original time period, file a request for an extension of time to complete its assessment. The court may grant additional time, not to exceed 7 days after the date of the renewal order, for the completion of the involuntary assessment and stabilization of the individual. The original court order authorizing the involuntary assessment and stabilization, or a request for an extension of time to complete the assessment and stabilization that is timely filed pursuant to this section, constitutes legal authority to involuntarily hold the individual for a period not to exceed 10 days in the absence of a court order to the contrary. S. 397.6821, F.S.

<sup>81</sup> S. 397.6811, F.S. The individual may also be ordered to a less restrictive component of a licensed service provider for assessment only upon entry of a court order or upon receipt by the licensed service provider of a petition

<sup>82</sup> S. 397.6819, F.S., The licensed service provider must assess the individual without unnecessary delay using a qualified professional. If an assessment is performed by a qualified professional who is not a physician, the assessment must be reviewed by a physician before the end of the assessment period.

<sup>83</sup> S. 397.6822, F.S. The timely of a Petition for Involuntary Treatment authorizes the service provider to retain physical custody of the individual pending further order of the court.

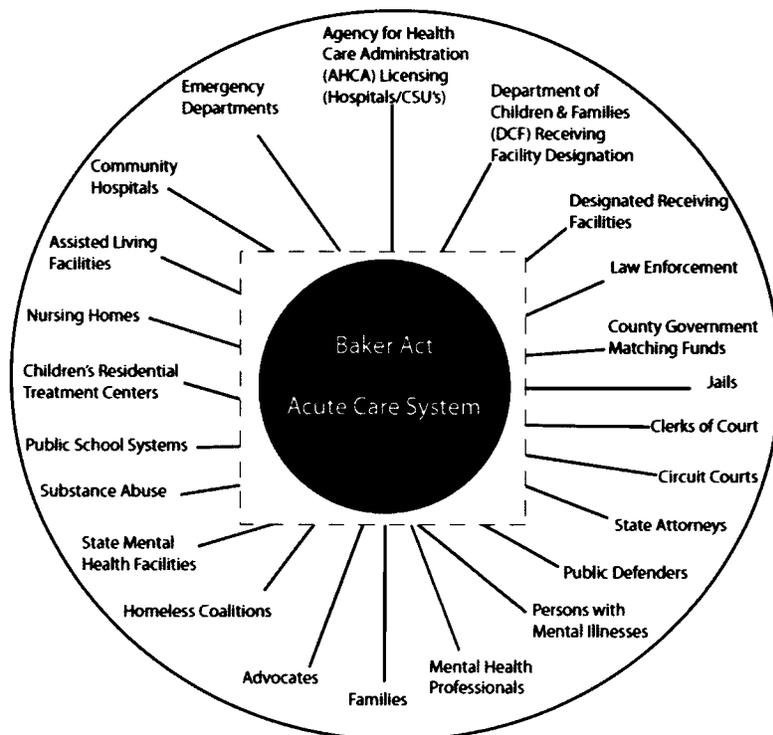
admissions procedures within a specified period.<sup>84</sup> Similar to a petition for involuntary assessment and stabilization, a petition for involuntary treatment must contain the same identifying information for all parties and attorneys and facts to support the need for involuntary treatment including the reason for the petitioner's belief that:

- The respondent is substance abuse impaired; and
- The respondent has lost the power of self-control with respect to substance abuse; and either that
  - The respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted; or
  - The respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.<sup>85</sup>

A treatment hearing must be scheduled within 10 days after the petition is filed. Under this provision if the court finds that the conditions for involuntary substance abuse treatment have been proven, it may order the respondent to undergo involuntary treatment with a licensed service provider for a period not to exceed 60 days.<sup>86</sup> The statute does not expressly state whether the individual must be sent to a publicly or privately funded service provider.

### Behavioral Health Acute Care System

The behavioral health acute care system is extraordinarily complex. This graphic indicates the entities involved in the system regarding mental health specifically. Additional entities are involved regarding substance abuse, such as addictions receiving facilities and detoxification units.



Source: Florida Mental Health Institute, USF, 2014 Baker Act User Reference Guide.

<sup>84</sup> S. 397.693, F.S.

<sup>85</sup> S. 397.6951, F.S.

<sup>86</sup> If the need for treatment is longer, renewal of the order may be petitioned prior to the expiration of the initial 60-day period.

Various state and federal laws and associated regulations govern the operation of and interaction between these entities in the performance of their duties relating to behavioral health acute care. Examples include:

- Federal:
  - Emergency Medical Treatment and Active Labor Act<sup>87</sup>, which applies to all hospitals with emergency service capacity, including freestanding psychiatric hospitals. The law prohibits the delay or denial of emergency medical services, including psychiatric or substance abuse emergencies, due to inability to pay.<sup>88</sup>
- State:
  - Baker Act and other provisions of ch. 394, F.S., governing the operation of the mental health system, including those governing transportation of clients, local match for mental health services, and the managing entity system.
  - Marchman Act and other provisions of ch. 397, F.S., including those governing substance abuse facility licensure.
  - Access to emergency services and care, s. 396.1041, F.S., which also prohibits the delay or denial of emergency services by hospitals. It governs access to care and transfers from a hospital.
  - Guardianship, ch. 744, F.S., through which an individual is adjudicated incompetent and a guardian appointed.
  - Advance directives, ch. 765, F.S., which addresses advanced planning for incapacity and surrogate health care decisionmakers and proxies.
  - Medicaid, ch. 409, which governs the operation of the state's medical assistance program. For example, managed care plans must offer at a minimum mental health services and substance abuse treatment services.<sup>89</sup>

Other laws, such as federal law regarding the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants, which fund safety-net services, and confidentiality of client records govern behavioral health care generally and also affect the operation of the behavioral health acute care system.

Funding for services provided in this system comes from a variety of sources, including but not limited to local government funding<sup>90</sup>, state general revenue, federal block grant funds, Medicaid, private insurance, and client fees<sup>91</sup>.

Pursuant to s. 394.9082(6)(a), F.S., managing entities are tasked with demonstrating the ability of their networks of providers to comply with the pertinent provisions of both the Baker and Marchman Acts. However, managing entities are not specifically charged with overseeing planning for the effective operation of the behavioral health acute care system.

Provisions of ch. 394 and 397 govern transportation to and among facilities, though the Baker Act is more detailed than the Marchman Act. For instance, s. 394.462, F.S., specifies that law enforcement transports individuals for involuntary admission to the nearest receiving facility, except under very specific circumstances. In contrast, transportation to emergency assessment and stabilization under the Marchman Act may be provided by a variety of parties such as the applicant for the person's emergency admission, his or her spouse or guardian, law enforcement officer, or health officer.<sup>92</sup> Neither act requires formal planning for transportation to support the community's behavioral health

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<sup>87</sup> 42 U.S.C. 1395dd.

<sup>88</sup> *Florida Mental Health Institute, USF, 2014 Baker Act User Reference Guide.*

<sup>89</sup> s. 409.973(1)(q) and (bb), F.S.

<sup>90</sup> s. 394.76, F.S.

<sup>91</sup> s. 394.674(3), F.S.

<sup>92</sup> s. 397.6795, F.S.

acute care system, though the Baker Act allows for counties to exempt themselves from certain statutory transportation requirements under certain circumstances.<sup>93</sup>

### Suitability Assessments for Children in the Child Welfare System

Section 39.407, F.S., provides a process for assessing a child in the legal custody of DCF for suitability for residential mental health treatment. This assessment must be conducted by a qualified evaluator and evaluates whether the child appears to have an emotional disturbance serious enough to require treatment, the child has had the treatment explained to him or her, and no less restrictive modalities are available. The Medicaid plan may be financially responsible for the child's residential treatment, if the child is served by one; however, statute does not require the plan to receive a copy of the assessment.

### Social Work, Therapy and Counseling Interns

In Florida, an individual may register as an intern in clinical social work, marriage and family therapy, or mental health counseling. Registering as an intern enables an individual to gain the required postgraduate or postmaster's clinical experience that is required for full licensure. Currently, 1,500 hours of face-to-face psychotherapy is required, which may not be accrued in fewer than 100 weeks.<sup>94</sup>

An applicant seeking registration as an intern must:<sup>95</sup>

- Submit the application form and the nonrefundable fee;
- Complete the education requirements;
- Submit an acceptable supervision plan for meeting the practicum, internship, or field work required for licensure that was not satisfied by graduate studies; and
- Identify a qualified supervisor.

Currently, an intern may renew his or her registration every biennium, with no limit on the number of times a registration may be renewed.

A provisional license allows individual practice, under supervision a licensed mental health professional, while not meeting all of the clinical experience requirements. Individuals must meet minimum coursework requirements, and possess the appropriate graduate degree. A provisional license is valid for 2 years.<sup>96</sup>

## **Effect of the Proposed Changes**

### Substance Abuse and Mental Health Program

The bill creates section 397.402, F.S., which requires DCF and the Agency for Health Care Administration (AHCA) to develop a plan for modifying licensure statutes and rules to provide options for a single, consolidated license for a provider that offers multiple types of mental health and substance abuse services regulated under chapters 394 and 397. The plan must identify options for license consolidation within DCF and AHCA, as well as identify inter-agency license consolidation options. The bill requires DCF and AHCA to submit the plan to the Governor, President of the Senate, and Speaker of the House of Representatives by November 1, 2016.

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<sup>93</sup> s. 394.462(4), F.S.

<sup>94</sup> Rule 64B4-2.001, F.A.C.

<sup>95</sup> Section 491.005, F.S.

<sup>96</sup> Section 491.0046, F.S. and Rule 64B-3.0075, F.A.C.

## *Behavioral Health Managing Entities*

The bill revises definitions and creates new definitions, including:

- “Coordinated behavioral health system of care” to be a system of care that has earned designation by DCF as having achieved the standards required by subsection (8) of s. 394.9082, F.S.
- “Managed behavioral health organization” as a Medicaid managed care organization currently under contract with the Medicaid managed medical assistance program or a behavioral health specialty managed care organization established pursuant to part IV of chapter 409.
- “Managing entity” to be a corporation selected by DCF to execute the administrative duties defined in the section to facilitate the delivery of behavioral health services through a coordinated behavioral health system of care.
- “Subregion” as a distinct portion of a managing entity’s geographic region defined by unifying service and provider utilization patterns.

The bill amends s. 394.9082(4)(a), F.S., to allow, in limited circumstances, entities other than nonprofit organizations to serve as managing entities. DCF must first attempt to contract with nonprofit organizations for the delivery of these services. If fewer than two responsive bids are received to a solicitation, DCF must reissue the solicitation, and managed behavioral health organizations will be eligible to bid in addition to nonprofit organizations. However, the bill requires all for-profit and not-for-profit contractors serving as managing entities to operate under the same contractual requirements.

The bill specifies the duties of the managing entity to include:

- serving as the leader in its geographic area in behavioral health services provision,
- encouraging collaboration and coordination among the many organizations and systems involving in meeting the geographic area’s behavioral health care needs;
- assessing community needs;
- contracting with service providers;
- monitoring provider performance;
- collecting and reporting data;
- facilitating effective provider relationships;
- working to improve access to and effectiveness, quality, and outcomes of behavioral health services;
- assisting local providers with securing local matching funds; and
- administrative and fiscal management duties necessary to comply with federal grant reporting.

The bill amends s. 394.9082(6), F.S., to specify behavioral health system of care elements. These elements may be funded by the managing entity to the extent allowed by resources, or by other entities. Among elements the bill includes is consumer care coordination, specifying that managing entities, within available resources, shall provide for the provision of care coordination to facilitate the appropriate delivery of behavioral health care services for specific target populations:

- **Priority Population I-** Individuals with serious mental illness or substance abuse disorders who have been admitted multiple times to acute levels of care, state mental health treatment facilities, jails, or prison;
- **Priority Population II-**
  - Individuals in receiving facilities or crisis stabilization units who are on the waitlist to a state treatment facility;
  - Individuals in state treatment facilities who are on the wait list for community-based care;
  - Children who are involved in the child welfare system but are not in out-of-home care;
  - Parents or caretakers of children who are involved in the child welfare system; and
  - Individuals who account for a disproportionate amount of behavioral health expenditures; and
- **Priority Population III-** Other individuals eligible for services.

The care coordination must address the recovery support needs of the consumer. This includes coordination with other local systems and entities, public and private, that are involved with the consumer, such as primary health care, child welfare, behavioral health care, and criminal and juvenile justice. To the extent allowable by available resources, support services provided through care coordination may include:

- Supportive housing;
- Supported employment;
- Family support and education;
- Independent living skill development;
- Peer support;
- Wellness management and self-care; and
- Case management.

The bill amends s. 394.9082(6)(e), F.S., to require managing entities and coordinated care organizations to work with the civil court system to develop procedures for the evaluation and use of involuntary outpatient placement for individuals as a strategy for diverting future admissions to acute levels of care, jails, prisons, and forensic facilities, subject to the availability of funding for services.

The bill amends s. 394.9082(6)(f), F.S., to allow DCF to develop additional data points which the managing entities must collect and submit, in addition to the required data points of persons served, outcomes of persons served, and the costs of services provided through the department's contract. The managing entities must report outcomes for all clients who have been served through the contract as long as they are clients of a network provider. DCF, to the extent possible, must use applicable measures based on nationally recognized standards. Examples of such standards exclude the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's National Outcome Measures or those developed by the National Quality Forum, the National Committee for Quality Assurance, or similar credible sources.

The bill additionally amends s. 394.9082(6)(f), F.S., to require DCF to work with managing entities to establish additional performance measures related to, at a minimum:

- The improvement in the overall behavioral health of a community;
- The improvement in functioning or progress in recovery of individuals served through care coordination;
- Success of strategies to divert admissions to acute levels of care.

The bill requires managing entities that are not managed behavioral health organizations to include representatives of law enforcement, the courts, and the community-based care lead agency, as well as individuals with business expertise, on its governing board. Managing entities must create a transparent process for nomination. If the managing entity is a managed behavioral health organization, it must have an advisory board that meets the requirements of s. 394.9082(7)(a), F.S. The bill requires the advisory board of a managed behavioral health organization to make recommendations to DCF about the renewal of the managing entity's or coordinated care organization's contract or the award of a new contract to the managing entity or coordinated care organization.

The bill provides managing entities flexibility to determine their network participants but requires them to have a process for publicizing opportunities for providers to join the network and evaluating to determine whether a provider may be part of its network.

The bill creates a new subsection addressing coordinated behavioral health system of care designation and community planning. It provides for managing entities to earn the coordinated behavioral health system of care designation by developing and implementing plans in a collaborative manner that

facilitate coordination between their network providers and other systems of care, such as the child welfare and Medicaid systems. The plans must specifically address coordination within and between the prevention and diversion subsystem, the coordinated receiving system, and the treatment and recovery support subsystem, and other major systems. The bill specifies deadlines for key steps in the process, including for managing entities under contract on July 1, 2016:

- DCF issues measurable minimum standards for earning the coordinated behavioral health system of care designation by November 30, 2016;
- Managing entities submit their plans for earning the designation by June 30, 2017;
- DCF approving plans by September 30, 2017;
- Managing entity reports on current status and progress during the previous fiscal year by September 30, 2018, and 2019, and
- DCF determines whether the managing entities have earned the designation by October 31, 2019.

DCF may renew the contracts of managing entities that earn the designation of having a coordinated behavioral health system of care for an additional term, provided other contract requirements and performance standards are met.

Managing entities initially contracted by the state after July 1, 2016, must earn the coordinated behavioral health system of care designation within three years of the contract execution date. DCF shall set deadlines for submitting plans and reports and may also renew the contracts of such managing entities that successfully earn the coordinated behavioral health coordinated system of care designation, provided other contract requirements and performance standards are met.

Annually by February 1, beginning in 2018, managing entities shall develop using an inclusive process and submit to DCF a plan for phased enhancement of the subsystems, by subregion, based on the assessed behavioral health needs of the subregion and system gaps. If the plan recommends additional funding, it must include specific information about those recommendations, including the needs to be met, services to be purchased, likely benefits of the services, projected costs, and number of individuals projected to benefit.

The bill also deletes a variety of obsolete requirements, primarily those relating to the transition to the managing entity structure. Some examples are provisions addressing the initial funding for managing entities, the phase-in of their responsibilities, and reporting on the transition.

### *Revenue Maximization*

The bill creates s. 394.761, F.S., which requires AHCA and DCF to develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care. The plan must identify the amount of general revenue funding appropriated for mental health and substance abuse services which is eligible to be used as state Medicaid match. The plan must also evaluate alternative uses of increased Medicaid funding and identify the advantages and disadvantages of each alternative. AHCA and DCF are required to submit the written plan to the President of the Senate and the Speaker of the House of Representatives no later than November 1, 2016.

### Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Program

The bill amends s. 394.656, F.S., and converts the Statewide Grant Review Committee to the Statewide Grant Policy Committee. The Policy Committee will consist of the existing members of the Review Committee and the following representatives:

- One representative of the Department of Veterans' Affairs;
- One representative of the Florida Sheriffs Association;
- One representative of the Florida Police Chiefs Association;

- One representative of the Florida Association of Counties;
- One representative of the Florida Alcohol and Drug Abuse Association;
- One representative of the Florida Association of Managing Entities;
- One representative of the Florida Council for Community Mental Health;
- One representative of the Florida Prosecuting Attorneys Association;
- One representative of the Florida Public Defender Association; and
- One administrator of a state-licensed limited mental health assisted living facility.

The Policy Committee will serve as the advisory body to review policy and funding issues that help reduce the impact of persons with mental illnesses and substance use disorders on communities, criminal justice agencies, and the court system. The bill requires DCF to create a grant review and selection committee which will be responsible for evaluating grant applications and selecting recipients. The grant review and selection committee will notify DCF of its selections.

Currently under s. 394.656, F.S., only a county or a consortium of counties may apply for a grant under the Program. The bill amends this section to additionally allow a county planning council or committee to designate a not-for-profit community provider or a managing entity to apply for a grant. A not-for-profit community provider or a managing entity must have express, written authorization from the county to apply for a grant to ensure local matching funds are available.

The bill amends s. 394.656, F.S., to authorize DCF to require, at its discretion, an applicant to conduct sequential intercept mapping for a project. The bill defines sequential intercept mapping as a process for reviewing a local community's mental health, substance abuse, criminal justice, and related systems and identifying points of interceptions where interventions may be made to prevent an individual with a substance use disorder or mental illness from penetrating further into the criminal justice system.

## Florida Mental Health Act

### *Involuntary Inpatient Placement*

Section 394.467(6)(b) requires the court to order an individual to receive services from a receiving or treatment facility, on an involuntary basis, for a period of up to 6 months. The bill amends this section to prohibit courts from ordering an individual with traumatic brain injury or dementia, who lacks a co-occurring mental illness, to be involuntarily placed in a state treatment facility.

### *Transportation*

The bill revises current law regarding exceptions to requirements for transportation to receiving facilities. The bill provides that counties may develop transportation exception plans, and groups of nearby counties may develop shared transportation plans. Counties' governing boards, managing entities, and DCF must approve plans before they are implemented. While such plans are optional, the bill requires counties, during the process provided in the bill in s. 394.9082(8), F.S., for managing entities to plan for a coordinated behavioral health system of care, to evaluate whether use of a transportation exception plan would enhance the functioning of the coordinated receiving system.

The bill also clarifies that law enforcement may transport an individual to a receiving facility other than the nearest one pursuant to the county's transportation exception plan.

## Marchman Act

DCF publishes limited forms for Marchman Act pleadings and reporting. The bill amends the Marchman Act to require DCF to develop and publish standard forms for pleadings and reporting. This includes forms for petition for involuntary admissions and forms for the initiation of protective custody by law

enforcement. The bill also requires DCF to notify the courts, law enforcement and other state agencies of the existence and availability of these forms.

Currently, there are no express reporting requirements for the Marchman Act. Conversely, the Baker Act has robust reporting requirements. The bill amends the Marchman Act to require reporting requirements on par with those of the Baker Act. As such, the bill requires DCF to create a statewide database for collecting utilization data for detoxification unit and addiction receiving facilities services under the Marchman Act funded by DCF.

Section 397.6772, F.S. authorizes law enforcement to take an individual meeting involuntary admission criteria under the Marchman Act into protective custody. The statute does not require law enforcement to execute a report. The bill amends this section to require law enforcement to execute a DCF created form when initiating protective custody. The reporting requirement is only applicable if law enforcement is taking the individual to a hospital or a licensed detoxification or addictions receiving facility.

The bill makes various changes to court proceedings under the Marchman Act. The bill amends s. 397.681, F.S., to prohibit the court from charging a filing fee for petitions filed under the Marchman Act. The bill also amends s. 397.6955, F.S., to allow for a continuance of the hearing on the petition for involuntary treatment. Finally, the bill amends s. 397.697, F.S., to expressly authorize the court to order an individual into involuntary treatment with a private funder service provider if the respondent has the ability to pay for the treatment, or if any person on respondent's behalf, voluntarily demonstrates willingness and ability to pay for the treatment.

"Informed consent" is not defined in the Marchman Act. The bill amends s. 397.311, F.S., to define "informed consent" as consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. This is identical to the definition of "express and informed consent" in the Baker Act, which term is used in a similar manner to "informed consent" in the Marchman Act.

#### Social Work, Therapy and Counseling Interns

Section 491.0045, F.S., does not limit the number of times an individual may renew his or her intern registration. The bill amends this section and limits the validity of an intern registration to five years. The bill also prohibits renewal of an intern registration unless the individual has passed the theory and practice examination for clinical social work, marriage and family therapy, or mental health counseling.

The bill provides that a person who holds a provisional license may not apply for intern registration in the same profession; which closes an avenue that may be utilized by some to lengthen the time period to practice in the field, once the intern registration expires in 5 years, without obtaining full licensure.

#### Repeals

The bill repeals a number of obsolete and duplicative sections of statute, as follows.

- Section 394.4674, F.S., which requires DCF to complete a deinstitutionalization plan. This section was enacted in 1980 and is obsolete following further developments in federal law.
- Section 394.4985, F.S., which requires DCF's regions to develop and maintain an information and referral network. This duplicates other requirements.
- Section 397.331, F.S., which provides definitions and legislative intent related to state drug control.
- Section 394.745, F.S., which requires an annual report to the Legislature of compliance of substance abuse and mental health treatment providers under contract with DCF.
- Sections 397.6772, 397.697, and 397.801, F.S., requiring the Departments of Education, Corrections, Law Enforcement and Children and Families to each designate substance abuse

impairment coordinators, and for DCF to also designate full-time substance abuse impairment coordinators in each of its regions.

- Section 397.811, F.S., which expresses the Legislature's intent that substance abuse prevention and early intervention programs be funded.
- Section 397.821, F.S., authorizing each judicial circuit to establish juvenile substance abuse impairment prevention and early intervention councils to identify needs. The managing entity now performs these duties.
- Section 397.901, F.S., authorizing DCF to establish prototype juvenile addiction receiving facilities. This section was enacted in 1993, and these projects are completed.
- Section 397.93, F.S., specifying target populations for children's substance abuse services, which duplicates other statutory requirements. This duplicates other provisions of law.
- Section 397.94, F.S., requiring the DCF's regions to plan and provide for information and referral services regarding children's substance abuse services.
- Section 397.951, F.S., requiring DCF to ensure that treatment providers use sanctions provided elsewhere in law to keep children in substance abuse treatment.
- Sections 397.97 and 397.98, F.S., relating to the Children's Network of Care Demonstration Models, authorizing their operation for four years. These were originally established in 1999.

## B. SECTION DIRECTORY:

**Section 1:** Amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.

**Section 2:** Amends s. 394.4597, F.S., relating to persons to be notified; appointment of a patient's representative.

**Section 3:** Amends s. 394.462, F.S., relating to transportation.

**Section 4:** Amends s. 394.467, F.S., relating to involuntary inpatient placement

**Section 5:** Amends s. 394.656, F.S., relating to the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program.

**Section 6:** Creates s. 394.761, F.S., relating to revenue maximization.

**Section 7:** Amends s. 394.875, F.S., relating to crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.

**Section 8:** Amends s. 394.9082, F.S., relating to behavioral health managing entities.

**Section 9:** Amends s. 397.311, F.S., relating to definitions.

**Section 10:** Amends s. 397.321, F.S., relating to duties of the department.

**Section 11:** Creates s. 397.402, F.S., relating to single, consolidated licensure.

**Section 12:** Amends s. 397.6772, F.S., relating to protective custody without consent.

**Section 13:** Amends s. 397.681, F.S., relating to involuntary petitions; general provisions; court jurisdiction and right to counsel.

**Section 14:** Amends s. 397.6955, F.S., relating to duties of court upon filing a petition for involuntary treatment.

**Section 15:** Amends s. 397.697, F.S., relating to court determination and effect of court order for involuntary substance abuse treatment.

**Section 16:** Amends s. 409.967, F.S., relating to managed care plan accountability.

**Section 17:** Amends s. 409.973, F.S., relating to benefits.

**Section 18:** Amends s. 491.0045, F.S., relating to intern registration requirements.

**Section 19:** Repeals s. 394.4674, F.S., relating to plan and report.

**Section 20:** Repeals s. 394.4985, F.S., relating to districtwide information and referral network; implementation.

**Section 21:** Repeals s. 394.745, F.S., relating to annual report; compliance of providers under contract with department.

**Section 22:** Repeals s. 397.331, F.S., relating to definitions; legislative intent.

**Section 23:** Repeals s. 397.801, F.S., relating to substance abuse impairment coordination.

- Section 24:** Repeals s. 397.811, F.S., relating to juvenile substance abuse impairment coordination; legislative findings and intent.
- Section 25:** Repeals s. 397.821, F.S., relating to juvenile substance abuse impairment prevention and early intervention councils.
- Section 26:** Repeals s. 397.901, F.S., prototype juvenile addictions receiving facilities.
- Section 27:** Repeals s. 397.93, F.S., children's substance abuse services; target populations.
- Section 28:** Repeals s. 397.94, F.S., children's substance abuse services; information and referral network.
- Section 29:** Repeals s. 397.951, F.S., treatment and sanctions.
- Section 30:** Repeals s. 397.97, F.S., children's substance abuse services; demonstration models.
- Section 31:** Repeals s. 397.98, F.S., children's substance abuse services; utilization management.
- Section 32:** Amends s. 212.055, F.S., discretionary sales surtaxes; legislative intent; authorization and use of proceeds.
- Section 33:** Amends s. 394.657, F.S., relating to county planning councils or committees.
- Section 34:** Amends s. 394.658, F.S., relating to criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program requirements.
- Section 35:** Amends s. 394.9085, F.S., relating to behavioral provider liability.
- Section 36:** Amends s. 397.405, F.S., exemptions from licensure
- Section 37:** Amends s. 397.407, F.S., relating to licensure process; fees.
- Section 38:** Amends s. 397.416, F.S., relating to substance abuse treatment services; qualified professional.
- Section 39:** Amends s. 409.966, F.S., relating to eligible plans and selection.
- Section 40:** Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
- Section 41:** Provides an effective date of July 1, 2016, except as otherwise provided in the act.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

#### 1. Revenues:

None.

#### 2. Expenditures:

The bill requires DCF to create a statewide database for collecting utilization data for certain Marchman-Act initiated substance abuse services funded by DCF. DCF recommends achieving this through upgrades to the CSU database, which would also enhance the collection of and access to Baker Act data and information. DCF estimates that it will cost \$400,000 to implement these changes.<sup>97</sup>

### B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

#### 1. Revenues:

None.

#### 2. Expenditures:

None.

### C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The managing entities are required to submit plans to earn the coordinated behavioral health system of care designation and enhancement plans for the subsystems within their system of care. However, managing entities' current responsibilities include needs assessment and planning. Managing entities that earn the coordinated behavioral health system of care may have their contracts renewed even if a renewal is not authorized under the current terms of the contract, provided contract performance is satisfactory.

All entities licensed or funded by DCF or the AHCA, or funded or operated by the Department of Health, are required to cooperate with the development and implementation of coordinated behavioral health system of care designation plans. While this may be a workload impact, these entities may experience greater overall savings due to increased efficiency and effectiveness from enhanced coordination with other providers and systems.

### D. FISCAL COMMENTS:

None.

## III. COMMENTS

### A. CONSTITUTIONAL ISSUES:

#### 1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

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<sup>97</sup> Correspondence from DCF to the House of Representative's Children, Families and Seniors Subcommittee dated December 17, 2015, on file with the Children, Families and Seniors Subcommittee.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

#### **IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

1                                   A bill to be entitled  
2           An act relating to mental health and substance abuse;  
3           amending s. 39.407, F.S.; requiring information about  
4           a child's suitability for residential treatment to be  
5           provided to an additional recipient; amending s.  
6           394.4597, F.S.; specifying certain persons who are  
7           prohibited from being selected as a patient's  
8           representative; providing rights of a patient's  
9           representative; amending s. 394.462, F.S.; providing  
10          for transportation of a person to a facility other  
11          than the nearest receiving facility; providing for the  
12          development and implementation of transportation  
13          exception plans; amending 394.467, F.S.; prohibiting a  
14          court from ordering a person with traumatic brain  
15          injury or dementia who lacks a co-occurring mental  
16          illness to be involuntarily placed in a state  
17          treatment facility; amending s. 394.656, F.S.;  
18          renaming the Criminal Justice, Mental Health, and  
19          Substance Abuse Statewide Grant Review Committee;  
20          providing additional members of the committee;  
21          providing duties of the committee; directing the  
22          Department of Children and Families to create a grant  
23          review and selection committee; providing duties of  
24          the committee; authorizing a designated not-for-profit  
25          community provider or managing entity to apply for  
26          certain grants; providing eligibility requirements;

27 | defining the term "sequential intercept mapping";  
28 | revising provisions relating to the transfer of grant  
29 | funds by the department; creating s. 394.761, F.S.;  
30 | requiring the Agency for Health Care Administration  
31 | and the department to develop a plan to obtain federal  
32 | approval for increasing the availability of federal  
33 | Medicaid funding for behavioral health care to be used  
34 | for a specified purpose; requiring the agency and the  
35 | department to submit a written plan that contains  
36 | certain information to the Legislature by a specified  
37 | date; amending s. 394.875, F.S.; removing a limitation  
38 | on the number of beds in crisis stabilization units;  
39 | amending s. 394.9082, F.S.; revising legislative  
40 | findings and intent relating to behavioral health  
41 | managing entities; revising and providing definitions;  
42 | requiring, rather than authorizing, the department to  
43 | contract with not-for-profit community-based  
44 | organizations to serve as managing entities; deleting  
45 | provisions providing for contracting for services;  
46 | providing contractual responsibilities of a managing  
47 | entity; providing protocols for the department to  
48 | select a managing entity; providing duties of managing  
49 | entities; requiring the department to develop and  
50 | enforce measurable outcome standards that address  
51 | specified goals; providing specified elements in a  
52 | behavioral health system of care; revising the

53 | criteria that the department may use when adopting  
54 | rules and contractual standards relating to the  
55 | qualification and operation of managing entities;  
56 | deleting certain departmental responsibilities;  
57 | providing that managing entities may earn coordinated  
58 | behavioral health system of care designations by  
59 | developing and implementing certain plans; providing  
60 | requirements for the plans; providing for earning and  
61 | maintaining such designation; requiring plans for  
62 | phased enhancement of the coordinated behavioral  
63 | health system of care; deleting a provision requiring  
64 | an annual report to the Legislature; authorizing,  
65 | rather than requiring, the department to adopt rules;  
66 | amending s. 397.311, F.S.; defining the term "informed  
67 | consent"; amending s. 397.321, F.S.; requiring the  
68 | department to develop, implement, and maintain  
69 | standards and protocols for the collection of  
70 | utilization data for addictions receiving facility and  
71 | detoxification services provided with department  
72 | funding; specifying data to be collected; requiring  
73 | reconciliation of data; providing timeframes for the  
74 | collection and submission of data; requiring the  
75 | department to create a statewide database to store the  
76 | data for certain purposes; requiring the department to  
77 | adopt rules; deleting a requirement for the department  
78 | to appoint a substance abuse impairment coordinator;

79 requiring the department to develop certain forms,  
 80 display such forms on its website, and notify certain  
 81 entities of the existence and availability of such  
 82 forms; creating s. 397.402, F.S.; requiring the  
 83 department and the agency to submit a plan to the  
 84 Governor and Legislature by a specified date with  
 85 options for modifying certain licensure statutes and  
 86 rules to provide for a single, consolidated license  
 87 for providers that offer certain mental health and  
 88 substance abuse services; amending s. 397.6772, F.S.;  
 89 requiring law enforcement officers to use standard  
 90 forms developed by the department to detail the  
 91 circumstances under which a person was taken into  
 92 custody under the Hal S. Marchman Alcohol and Other  
 93 Drug Services Act; amending s. 397.681, F.S.;  
 94 prohibiting the court from charging a fee for the  
 95 filing of petitions for involuntary assessment and  
 96 stabilization and involuntary treatment; amending s.  
 97 397.6955, F.S.; authorizing a continuance to be  
 98 granted for a hearing on involuntary treatment of a  
 99 substance abuse impaired person; amending s. 397.697,  
 100 F.S.; allowing the court to order a respondent to  
 101 undergo treatment through a privately funded licensed  
 102 service provider under certain conditions; amending s.  
 103 409.967, F.S.; requiring managed care plan contracts  
 104 to include specified requirements; amending s.

105 | 409.973, F.S.; requiring each plan operating in the  
106 | managed medical assistance program to work with the  
107 | managing entity in its service area to establish  
108 | specific organizational supports and service  
109 | protocols; amending s. 491.0045, F.S.; revising  
110 | requirements relating to interns; limiting an intern  
111 | registration to 5 years; providing timelines for  
112 | expiration of certain intern registrations; providing  
113 | requirements for issuance of subsequent registrations;  
114 | prohibiting an individual who held a provisional  
115 | license issued by the board from applying for an  
116 | intern registration in the same profession; repealing  
117 | s. 394.4674, F.S., relating to a plan and report;  
118 | repealing s. 394.4985, F.S., relating to districtwide  
119 | information and referral network and implementation;  
120 | repealing s. 394.745, F.S., relating to an annual  
121 | report and compliance of providers under contract with  
122 | the department; repealing s. 397.331, F.S., relating  
123 | to definitions; repealing s. 397.801, F.S., relating  
124 | to substance abuse impairment coordination; repealing  
125 | s. 397.811, F.S., relating to juvenile substance abuse  
126 | impairment coordination; repealing s. 397.821, F.S.,  
127 | relating to juvenile substance abuse impairment  
128 | prevention and early intervention councils; repealing  
129 | s. 397.901, F.S., relating to prototype juvenile  
130 | addictions receiving facilities; repealing s. 397.93,

131 F.S., relating to children's substance abuse services  
 132 and target populations; repealing s. 397.94, F.S.,  
 133 relating to children's substance abuse services and  
 134 the information and referral network; repealing s.  
 135 397.951, F.S., relating to treatment and sanctions;  
 136 repealing s. 397.97, F.S., relating to children's  
 137 substance abuse services and demonstration models;  
 138 repealing s. 397.98, F.S., relating to children's  
 139 substance abuse services and utilization management;  
 140 amending ss. 212.055, 394.657, 394.658, 394.9085,  
 141 397.405, 397.407, 397.416, 409.966, and 440.102, F.S.;  
 142 conforming provisions and cross-references to changes  
 143 made by the act; providing effective dates.

144

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

146

147 Section 1. Paragraph (c) of subsection (6) of section  
 148 39.407, Florida Statutes, is amended to read:

149 39.407 Medical, psychiatric, and psychological examination  
 150 and treatment of child; physical, mental, or substance abuse  
 151 examination of person with or requesting child custody.—

152 (6) Children who are in the legal custody of the  
 153 department may be placed by the department, without prior  
 154 approval of the court, in a residential treatment center  
 155 licensed under s. 394.875 or a hospital licensed under chapter  
 156 395 for residential mental health treatment only pursuant to

157 | this section or may be placed by the court in accordance with an  
 158 | order of involuntary examination or involuntary placement  
 159 | entered pursuant to s. 394.463 or s. 394.467. All children  
 160 | placed in a residential treatment program under this subsection  
 161 | must have a guardian ad litem appointed.

162 | (c) Before a child is admitted under this subsection, the  
 163 | child shall be assessed for suitability for residential  
 164 | treatment by a qualified evaluator who has conducted a personal  
 165 | examination and assessment of the child and has made written  
 166 | findings that:

167 | 1. The child appears to have an emotional disturbance  
 168 | serious enough to require residential treatment and is  
 169 | reasonably likely to benefit from the treatment.

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

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

177 |  
 178 | A copy of the written findings of the evaluation and suitability  
 179 | assessment must be provided to the department, ~~and~~ to the  
 180 | guardian ad litem, and to the child's Medicaid managed care  
 181 | plan, if applicable, which entities ~~who~~ shall have the  
 182 | opportunity to discuss the findings with the evaluator.

HB 7097

2016

183 Section 2. Section 394.4597, Florida Statutes, is amended  
 184 to read:

185 394.4597 Persons to be notified; designation of a  
 186 patient's representative.-

187 (1) VOLUNTARY PATIENTS.- At the time a patient is  
 188 voluntarily admitted to a receiving or treatment facility, the  
 189 patient shall be asked to identify a person to be notified in  
 190 case of an emergency, and the identity and contact information  
 191 of that a person to be notified in case of an emergency shall be  
 192 entered in the patient's clinical record.

193 (2) INVOLUNTARY PATIENTS.-

194 (a) At the time a patient is admitted to a facility for  
 195 involuntary examination or placement, or when a petition for  
 196 involuntary placement is filed, the names, addresses, and  
 197 telephone numbers of the patient's guardian or guardian  
 198 advocate, or representative if the patient has no guardian, and  
 199 the patient's attorney shall be entered in the patient's  
 200 clinical record.

201 (b) If the patient has no guardian, the patient shall be  
 202 asked to designate a representative. If the patient is unable or  
 203 unwilling to designate a representative, the facility shall  
 204 select a representative.

205 (c) The patient shall be consulted with regard to the  
 206 selection of a representative by the receiving or treatment  
 207 facility and shall have authority to request that any such  
 208 representative be replaced.

209 (d) ~~If when~~ the receiving or treatment facility selects a  
 210 representative, first preference shall be given to a health care  
 211 surrogate, if one has been previously selected by the patient.  
 212 If the patient has not previously selected a health care  
 213 surrogate, the selection, except for good cause documented in  
 214 the patient's clinical record, shall be made from the following  
 215 list in the order of listing:

- 216 1. The patient's spouse.
- 217 2. An adult child of the patient.
- 218 3. A parent of the patient.
- 219 4. The adult next of kin of the patient.
- 220 5. An adult friend of the patient.
- 221 6. The appropriate Florida local advocacy council as  
 222 provided in s. 402.166.

223 (e) The following persons are prohibited from selection as  
 224 a patient's representative:

- 225 1. A professional providing clinical services to the  
 226 patient under this part;
- 227 2. The licensed professional who initiated the involuntary  
 228 examination of the patient, if the examination was initiated by  
 229 professional certificate;
- 230 3. An employee, administrator, or board member of the  
 231 facility providing the examination of the patient;
- 232 4. An employee, administrator, or board member of a  
 233 treatment facility providing treatment of the patient;
- 234 5. A person providing any substantial professional

235 services for the patient, including clinical and nonclinical  
 236 services;  
 237 6. A creditor of the patient;  
 238 7. A person subject to an injunction for protection  
 239 against domestic violence under s. 741.30, whether the order of  
 240 injunction is temporary or final, for which the patient was the  
 241 petitioner; and  
 242 8. A person subject to an injunction for protection  
 243 against repeat violence, sexual violence, or dating violence  
 244 under s. 784.046, whether the order of injunction is temporary  
 245 or final, for which the patient was the petitioner.  
 246 (f) The representative selected by the patient or  
 247 designated by the facility has the right to:  
 248 1. Receive notice of the patient's admission;  
 249 2. Receive notice of proceedings affecting the patient;  
 250 3. Have access to the patient within reasonable timelines  
 251 in accordance with the provider's publicized visitation policy,  
 252 unless such access is documented to be detrimental to the  
 253 patient;  
 254 4. Receive notice of any restriction of the patient's  
 255 right to communicate or receive visitors;  
 256 5. Receive a copy of the inventory of personal effects  
 257 upon the patient's admission and request an amendment to the  
 258 inventory at any time;  
 259 6. Receive disposition of the patient's clothing and  
 260 personal effects, if not returned to the patient, or approve an

261 alternate plan for disposition of such clothing and personal  
 262 effects;

263 7. Petition on behalf of the patient for a writ of habeas  
 264 corpus to question the cause and legality of the patient's  
 265 detention or to allege that the patient is being unjustly denied  
 266 a right or privilege granted under this part, or that a  
 267 procedure authorized under this part is being abused;

268 8. Apply for a change of venue for the patient's  
 269 involuntary placement hearing for the convenience of the parties  
 270 or witnesses or because of the patient's condition;

271 9. Receive written notice of any restriction of the  
 272 patient's right to inspect his or her clinical record;

273 10. Receive notice of the release of the patient from a  
 274 receiving facility at which an involuntary examination was  
 275 performed;

276 11. Receive a copy of any petition for the patient's  
 277 involuntary placement filed with the court; and

278 12. Be informed by the court of the patient's right to an  
 279 independent expert evaluation pursuant to involuntary placement  
 280 procedures.

281 ~~(e) A licensed professional providing services to the~~  
 282 ~~patient under this part, an employee of a facility providing~~  
 283 ~~direct services to the patient under this part, a department~~  
 284 ~~employee, a person providing other substantial services to the~~  
 285 ~~patient in a professional or business capacity, or a creditor of~~  
 286 ~~the patient shall not be appointed as the patient's~~

287 ~~representative.~~

288 Section 3. Section 394.462, Florida Statutes, is amended  
 289 to read:

290 394.462 Transportation.--

291 (1) TRANSPORTATION TO A RECEIVING FACILITY.--

292 (a) Each county shall designate a single law enforcement  
 293 agency within the county, or portions thereof, to take a person  
 294 into custody upon the entry of an ex parte order or the  
 295 execution of a certificate for involuntary examination by an  
 296 authorized professional and to transport that person to the  
 297 nearest receiving facility for examination, unless the  
 298 transportation exception plan developed pursuant to subsection  
 299 (4) authorizes a law enforcement agency to transport the person  
 300 to another receiving facility. The designated law enforcement  
 301 agency may decline to transport the person to a receiving  
 302 facility only if:

303 1. The jurisdiction designated by the county has  
 304 contracted on an annual basis with an emergency medical  
 305 transport service or private transport company for  
 306 transportation of persons to receiving facilities pursuant to  
 307 this section at the sole cost of the county; and

308 2. The law enforcement agency and the emergency medical  
 309 transport service or private transport company agree that the  
 310 continued presence of law enforcement personnel is not necessary  
 311 for the safety of the person or others.

312 3. The jurisdiction designated by the county may seek

313 reimbursement for transportation expenses. The party responsible  
 314 for payment for such transportation is the person receiving the  
 315 transportation. The county shall seek reimbursement from the  
 316 following sources in the following order:

317       a. From an insurance company, health care corporation, or  
 318 other source, if the person receiving the transportation is  
 319 covered by an insurance policy or subscribes to a health care  
 320 corporation or other source for payment of such expenses.

321       b. From the person receiving the transportation.

322       c. From a financial settlement for medical care,  
 323 treatment, hospitalization, or transportation payable or  
 324 accruing to the injured party.

325       (b) A ~~Any~~ company that transports a patient pursuant to  
 326 this subsection is considered an independent contractor and is  
 327 solely liable for the safe and dignified transportation of the  
 328 patient. Such company must be insured and provide no less than  
 329 \$100,000 in liability insurance with respect to the  
 330 transportation of patients.

331       (c) A ~~Any~~ company that contracts with a governing board of  
 332 a county to transport patients shall comply with the applicable  
 333 rules of the department to ensure the safety and dignity of the  
 334 patients.

335       (d) When a law enforcement officer takes custody of a  
 336 person pursuant to this part, the officer may request assistance  
 337 from emergency medical personnel if such assistance is needed  
 338 for the safety of the officer or the person in custody.

339 (e) When a member of a mental health overlay program or a  
340 mobile crisis response service is a professional authorized to  
341 initiate an involuntary examination pursuant to s. 394.463 and  
342 that professional evaluates a person and determines that  
343 transportation to a receiving facility is needed, the service,  
344 at its discretion, may transport the person to the facility or  
345 may call on the law enforcement agency or other transportation  
346 arrangement best suited to the needs of the patient.

347 (f) When a ~~any~~ law enforcement officer has custody of a  
348 person based on either noncriminal or minor criminal behavior  
349 that meets the statutory guidelines for involuntary examination  
350 under this part, the law enforcement officer shall transport the  
351 person to the nearest receiving facility for examination, unless  
352 the transportation exception plan developed pursuant to  
353 subsection (4) authorizes the law enforcement officer to  
354 transport the person to another receiving facility.

355 (g) When a ~~any~~ law enforcement officer has arrested a  
356 person for a felony and it appears that the person meets the  
357 statutory guidelines for involuntary examination or placement  
358 under this part, such person shall first be processed in the  
359 same manner as any other criminal suspect. The law enforcement  
360 agency shall thereafter immediately notify the nearest public  
361 receiving facility, which shall be responsible for promptly  
362 arranging for the examination and treatment of the person. A  
363 receiving facility is not required to admit a person charged  
364 with a crime for whom the facility determines and documents that

365 | it is unable to provide adequate security, but shall provide  
366 | mental health examination and treatment to the person where he  
367 | or she is held.

368 |       (h) If the appropriate law enforcement officer believes  
369 | that a person has an emergency medical condition as defined in  
370 | s. 395.002, the person may be first transported to a hospital  
371 | for emergency medical treatment, regardless of whether the  
372 | hospital is a designated receiving facility.

373 |       (i) The costs of transportation, evaluation,  
374 | hospitalization, and treatment incurred under this subsection by  
375 | persons who have been arrested for violations of any state law  
376 | or county or municipal ordinance may be recovered as provided in  
377 | s. 901.35.

378 |       (j) The nearest receiving facility must accept persons  
379 | brought by law enforcement officers for involuntary examination.

380 |       (k) Each law enforcement agency shall develop a memorandum  
381 | of understanding with each receiving facility within the law  
382 | enforcement agency's jurisdiction which reflects a single set of  
383 | protocols for the safe and secure transportation of the person  
384 | and transfer of custody of the person. These protocols must also  
385 | address crisis intervention measures.

386 |       (l) When a jurisdiction has entered into a contract with  
387 | an emergency medical transport service or a private transport  
388 | company for transportation of persons to receiving facilities,  
389 | such service or company shall be given preference for  
390 | transportation of persons from nursing homes, assisted living

391 facilities, adult day care centers, or adult family-care homes,  
 392 unless the behavior of the person being transported is such that  
 393 transportation by a law enforcement officer is necessary.

394 (m) Nothing in this section shall be construed to limit  
 395 emergency examination and treatment of incapacitated persons  
 396 provided in accordance with the provisions of s. 401.445.

397 (2) TRANSPORTATION TO A TREATMENT FACILITY.—

398 (a) If neither the patient nor any person legally  
 399 obligated or responsible for the patient is able to pay for the  
 400 expense of transporting a voluntary or involuntary patient to a  
 401 treatment facility, the governing board of the county in which  
 402 the patient is hospitalized shall arrange for such required  
 403 transportation and shall ensure the safe and dignified  
 404 transportation of the patient. The governing board of each  
 405 county is authorized to contract with private transport  
 406 companies for the transportation of such patients to and from a  
 407 treatment facility.

408 (b) A ~~Any~~ company that transports a patient pursuant to  
 409 this subsection is considered an independent contractor and is  
 410 solely liable for the safe and dignified transportation of the  
 411 patient. Such company must be insured and provide no less than  
 412 \$100,000 in liability insurance with respect to the  
 413 transportation of patients.

414 (c) A ~~Any~~ company that contracts with the governing board  
 415 of a county to transport patients shall comply with the  
 416 applicable rules of the department to ensure the safety and

417 dignity of the patients.

418 (d) County or municipal law enforcement and correctional  
 419 personnel and equipment may ~~shall~~ not be used to transport  
 420 patients adjudicated incapacitated or found by the court to meet  
 421 the criteria for involuntary placement pursuant to s. 394.467,  
 422 except in small rural counties where there are no cost-efficient  
 423 alternatives.

424 (3) TRANSFER OF CUSTODY.—Custody of a person who is  
 425 transported pursuant to this part, along with related  
 426 documentation, shall be relinquished to a responsible individual  
 427 at the appropriate receiving or treatment facility.

428 (4) EXCEPTIONS.—

429 (a)1. Individual counties may each develop a  
 430 transportation exception plan, and groups of nearby counties,  
 431 operating under a memorandum of understanding, may each develop  
 432 a shared transportation exception plan ~~An exception to the~~  
 433 ~~requirements of this section may be granted by the secretary of~~  
 434 ~~the department for the purposes of improving service~~  
 435 ~~coordination or better meeting the special needs of individuals.~~

436 2. Such plans ~~A proposal for an exception~~ must be  
 437 ~~submitted by the district administrator after being~~ approved by  
 438 the counties' governing boards and by the managing entity before  
 439 submission to the department, and the department must approve  
 440 such plans before implementation ~~of any affected counties, prior~~  
 441 ~~to submission to the secretary.~~

442 3. During the process provided in s. 394.9082(7)

443 documenting the coordinated receiving system, each county shall  
 444 evaluate whether use of a transportation exception plan would  
 445 enhance the functioning of the coordinated receiving system and,  
 446 if so, shall develop a transportation exception plan or a shared  
 447 transportation exception plan that is coordinated with the  
 448 coordinated receiving system.

449 (b)~~(a)~~ A proposal for an exception must identify the  
 450 specific provision from which an exception is requested;  
 451 describe how the proposal will be implemented by participating  
 452 law enforcement agencies and transportation authorities; and  
 453 provide a plan for the coordination of services such as case  
 454 management.

455 (c)~~(b)~~ The exception may be granted ~~only~~ for:

456 1. An arrangement centralizing and improving the provision  
 457 of services ~~within a district~~, which may include an exception to  
 458 the requirement for transportation to the nearest receiving  
 459 facility;

460 2. An arrangement by which a facility may provide, in  
 461 addition to required psychiatric services, an environment and  
 462 services which are uniquely tailored to the needs of an  
 463 identified group of persons with special needs, such as persons  
 464 with hearing impairments or visual impairments, or elderly  
 465 persons with physical frailties; or

466 3. A specialized transportation system that provides an  
 467 efficient and humane method of transporting patients to  
 468 receiving facilities, among receiving facilities, and to

469 treatment facilities.

470 ~~(d)(e)~~ Any exception approved pursuant to this subsection  
 471 shall be reviewed and approved every 5 years by the secretary.

472 Section 4. Paragraph (b) of subsection (6) of section  
 473 394.467, Florida Statutes, is amended to read:

474 394.467 Involuntary inpatient placement.—

475 (6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.—

476 (b) If the court concludes that the patient meets the  
 477 criteria for involuntary inpatient placement, it shall order  
 478 that the patient be transferred to a treatment facility or, if  
 479 the patient is at a treatment facility, that the patient be  
 480 retained there or be treated at any other appropriate receiving  
 481 or treatment facility, or that the patient receive services from  
 482 a receiving or treatment facility, on an involuntary basis, for  
 483 a period of up to 6 months. The order shall specify the nature  
 484 and extent of the patient's mental illness. The court may not  
 485 order an individual with traumatic brain injury or dementia who  
 486 lacks a co-occurring mental illness to be involuntarily placed  
 487 in a state treatment facility. The facility shall discharge a  
 488 patient any time the patient no longer meets the criteria for  
 489 involuntary inpatient placement, unless the patient has  
 490 transferred to voluntary status.

491 Section 5. Section 394.656, Florida Statutes, is amended  
 492 to read:

493 394.656 Criminal Justice, Mental Health, and Substance  
 494 Abuse Reinvestment Grant Program.—

495 (1) There is created within the Department of Children and  
 496 Families the Criminal Justice, Mental Health, and Substance  
 497 Abuse Reinvestment Grant Program. The purpose of the program is  
 498 to provide funding to counties with which they can plan,  
 499 implement, or expand initiatives that increase public safety,  
 500 avert increased spending on criminal justice, and improve the  
 501 accessibility and effectiveness of treatment services for adults  
 502 and juveniles who have a mental illness, substance abuse  
 503 disorder, or co-occurring mental health and substance abuse  
 504 disorders and who are in, or at risk of entering, the criminal  
 505 or juvenile justice systems.

506 (2) The department shall establish a Criminal Justice,  
 507 Mental Health, and Substance Abuse Statewide Grant Policy Review  
 508 Committee. The committee shall include:

509 (a) One representative of the Department of Children and  
 510 Families;

511 (b) One representative of the Department of Corrections;

512 (c) One representative of the Department of Juvenile  
 513 Justice;

514 (d) One representative of the Department of Elderly  
 515 Affairs; ~~and~~

516 (e) One representative of the Office of the State Courts  
 517 Administrator;

518 (f) One representative of the Department of Veterans'  
 519 Affairs;

520 (g) One representative of the Florida Sheriffs

521 Association;  
 522 (h) One representative of the Florida Police Chiefs  
 523 Association;  
 524 (i) One representative of the Florida Association of  
 525 Counties;  
 526 (j) One representative of the Florida Alcohol and Drug  
 527 Abuse Association;  
 528 (k) One representative of the Florida Association of  
 529 Managing Entities;  
 530 (l) One representative of the Florida Council for  
 531 Community Mental Health;  
 532 (m) One representative of the Florida Prosecuting  
 533 Attorneys Association;  
 534 (n) One representative of the Florida Public Defender  
 535 Association; and  
 536 (o) One administrator of a state-licensed limited mental  
 537 health assisted living facility.  
 538 (3) The committee shall serve as the advisory body to  
 539 review policy and funding issues that help reduce the impact of  
 540 persons with mental illnesses and substance use disorders on  
 541 communities, criminal justice agencies, and the court system.  
 542 The committee shall advise the department in selecting  
 543 priorities for grants and investing awarded grant moneys.  
 544 (4) The department shall create a grant review and  
 545 selection committee that has experience in substance use and  
 546 mental health disorders, community corrections, and law

547 enforcement. To the extent possible, the ~~members of the~~  
 548 committee shall have expertise in ~~grant writing,~~ grant  
 549 reviewing~~,~~ and grant application scoring.

550 (5)(3)(a) A county, or not-for-profit community provider  
 551 or managing entity designated by the county planning council or  
 552 committee, as described in s. 394.657, may apply for a 1-year  
 553 planning grant or a 3-year implementation or expansion grant.  
 554 The purpose of the grants is to demonstrate that investment in  
 555 treatment efforts related to mental illness, substance abuse  
 556 disorders, or co-occurring mental health and substance abuse  
 557 disorders results in a reduced demand on the resources of the  
 558 judicial, corrections, juvenile detention, and health and social  
 559 services systems.

560 (b) To be eligible to receive a 1-year planning grant or a  
 561 3-year implementation or expansion grant:7

562 1. A county applicant must have a ~~county~~ planning council  
 563 or committee that is in compliance with the membership  
 564 requirements set forth in this section.

565 2. A not-for-profit community provider or managing entity  
 566 must be designated by the county planning council or committee  
 567 and have written authorization to submit an application. A not-  
 568 for-profit community provider or managing entity must have  
 569 written authorization for each application it submits.

570 (c) The department may award a 3-year implementation or  
 571 expansion grant to an applicant who has not received a 1-year  
 572 planning grant.

573        (d) The department may require an applicant to conduct  
 574 sequential intercept mapping for a project. For purposes of this  
 575 paragraph, the term "sequential intercept mapping" means a  
 576 process for reviewing a local community's mental health,  
 577 substance abuse, criminal justice, and related systems and  
 578 identifying points of interceptions where interventions may be  
 579 made to prevent an individual with a substance use disorder or  
 580 mental illness from deeper involvement in the criminal justice  
 581 system.

582        (6)-(4) The grant review and selection committee shall  
 583 select the grant recipients and notify the department of  
 584 Children and Families in writing of the recipients' names of the  
 585 applicants who have been selected by the committee to receive a  
 586 grant. Contingent upon the availability of funds and upon  
 587 notification by the grant review and selection committee of  
 588 those applicants approved to receive planning, implementation,  
 589 or expansion grants, the department ~~of Children and Families~~ may  
 590 transfer funds appropriated for the grant program to a selected  
 591 any county awarded a grant recipient.

592        Section 6. Section 394.761, Florida Statutes, is created  
 593 to read:

594        394.761 Revenue maximization.-The agency and the  
 595 department shall develop a plan to obtain federal approval for  
 596 increasing the availability of federal Medicaid funding for  
 597 behavioral health care. Increased funding shall be used to  
 598 advance the goal of improved integration of behavioral health

599 and primary care services for individuals eligible for Medicaid  
 600 through the development and effective implementation of  
 601 coordinated behavioral health systems of care as described in s.  
 602 394.9082. The agency and the department shall submit the written  
 603 plan to the President of the Senate and the Speaker of the House  
 604 of Representatives by November 1, 2016. The plan shall identify  
 605 the amount of general revenue funding appropriated for mental  
 606 health and substance abuse services which is eligible to be used  
 607 as state Medicaid match. The plan must evaluate alternative uses  
 608 of increased Medicaid funding, including seeking Medicaid  
 609 eligibility for the severely and persistently mentally ill or  
 610 persons with substance use disorders, increased reimbursement  
 611 rates for behavioral health services, adjustments to the  
 612 capitation rate for Medicaid enrollees with chronic mental  
 613 illness and substance use disorders, supplemental payments to  
 614 mental health and substance abuse providers through a designated  
 615 state health program or other mechanisms, and innovative  
 616 programs to provide incentives for improved outcomes for  
 617 behavioral health conditions. The plan shall identify the  
 618 advantages and disadvantages of each alternative and assess each  
 619 alternative's potential for achieving improved integration of  
 620 services. The plan shall identify the types of federal approvals  
 621 necessary to implement each alternative and project a timeline  
 622 for implementation.

623 Section 7. Paragraph (a) of subsection (1) of section  
 624 394.875, Florida Statutes, is amended to read:

625 | 394.875 Crisis stabilization units, residential treatment  
 626 | facilities, and residential treatment centers for children and  
 627 | adolescents; authorized services; license required.-

628 | (1)(a) The purpose of a crisis stabilization unit is to  
 629 | stabilize and redirect a client to the most appropriate and  
 630 | least restrictive community setting available, consistent with  
 631 | the client's needs. Crisis stabilization units may screen,  
 632 | assess, and admit for stabilization persons who present  
 633 | themselves to the unit and persons who are brought to the unit  
 634 | under s. 394.463. Clients may be provided 24-hour observation,  
 635 | medication prescribed by a physician or psychiatrist, and other  
 636 | appropriate services. Crisis stabilization units shall provide  
 637 | services regardless of the client's ability to pay ~~and shall be~~  
 638 | ~~limited in size to a maximum of 30 beds.~~

639 | Section 8. Effective upon this act becoming a law, section  
 640 | 394.9082, Florida Statutes, is amended to read:

641 | 394.9082 Behavioral health managing entities.-

642 | (1) LEGISLATIVE FINDINGS AND INTENT.-The Legislature finds  
 643 | that untreated behavioral health disorders constitute major  
 644 | health problems for residents of this state, are a major  
 645 | economic burden to the citizens of this state, and substantially  
 646 | increase demands on the state's juvenile and adult criminal  
 647 | justice systems, the child welfare system, and health care  
 648 | systems. The Legislature finds that behavioral health disorders  
 649 | respond to appropriate treatment, rehabilitation, and supportive  
 650 | intervention. The Legislature finds that the state's return on

651 | ~~its it has made a substantial long-term~~ investment in the  
 652 | funding of the community-based behavioral health prevention and  
 653 | treatment service systems and facilities can be enhanced for  
 654 | individuals also served by Medicaid through integration, and for  
 655 | individuals not served by Medicaid through coordination, of  
 656 | these services with primary care in order to provide critical  
 657 | ~~emergency, acute care, residential, outpatient, and~~  
 658 | ~~rehabilitative and recovery-based services.~~ The Legislature  
 659 | finds that local communities have also made substantial  
 660 | investments in behavioral health services, contracting with  
 661 | safety net providers who by mandate and mission provide  
 662 | specialized services to vulnerable and hard-to-serve populations  
 663 | and have strong ties to local public health and public safety  
 664 | agencies. The Legislature finds that a regional management  
 665 | structure that facilitates a comprehensive and cohesive system  
 666 | of coordinated care for ~~places the responsibility for publicly~~  
 667 | ~~financed~~ behavioral health treatment and prevention services  
 668 | ~~within a single private, nonprofit entity at the local level~~  
 669 | will improve ~~promote improved~~ access to care, promote service  
 670 | continuity, and provide for more efficient and effective  
 671 | delivery of substance abuse and mental health services. The  
 672 | Legislature finds that streamlining administrative processes  
 673 | will create cost efficiencies and provide flexibility to better  
 674 | match available services to consumers' identified needs.

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

676 | (a) "Behavioral health services" means mental health

677 services and substance abuse prevention and treatment services  
 678 as defined in this chapter and chapter 397 which are provided  
 679 using local match and state and federal funds.

680 (b) "Coordinated behavioral health system of care" means a  
 681 system of care that has earned designation by the department as  
 682 having achieved the standards required in subsection (7).

683 ~~"Decisionmaking model" means a comprehensive management~~  
 684 ~~information system needed to answer the following management~~  
 685 ~~questions at the federal, state, regional, circuit, and local~~  
 686 ~~provider levels: who receives what services from which providers~~  
 687 ~~with what outcomes and at what costs?~~

688 (c) "Geographic area" means one or more contiguous  
 689 counties, circuits, or regions as described in s. 409.966 a  
 690 ~~county, circuit, regional, or multiregional area in this state.~~

691 (d) "Managed behavioral health organization" means a  
 692 Medicaid managed care organization currently under contract with  
 693 the Medicaid managed medical assistance program in this state  
 694 pursuant to part IV of chapter 409, including a managed care  
 695 organization operating as a behavioral health specialty plan.

696 (e)~~(d)~~ "Managing entity" means a corporation that is  
 697 selected by ~~organized in this state, is designated or filed as a~~  
 698 ~~nonprofit organization under s. 501(c)(3) of the Internal~~  
 699 ~~Revenue Code, and is under contract to the department to execute~~  
 700 the administrative duties specified in this section to  
 701 facilitate the ~~manage the day-to-day operational~~ delivery of  
 702 behavioral health services through a coordinated behavioral

703 | health an organized system of care.

704 |       ~~(f)(e)~~ "Provider network networks" means mean the direct  
 705 | service agencies ~~that are~~ under contract with a managing entity  
 706 | to provide behavioral health services. The provider network may  
 707 | also include noncontracted providers as partners in the delivery  
 708 | of coordinated care and that together constitute a comprehensive  
 709 | array of emergency, acute care, residential, outpatient,  
 710 | recovery support, and consumer support services.

711 |       ~~(g)~~ "Subregion" means a distinct portion of a managing  
 712 | entity's geographic region defined by unifying service and  
 713 | provider utilization patterns.

714 |       ~~(3) SERVICE DELIVERY STRATEGIES. The department may work~~  
 715 | ~~through managing entities to develop service delivery strategies~~  
 716 | ~~that will improve the coordination, integration, and management~~  
 717 | ~~of the delivery of behavioral health services to people who have~~  
 718 | ~~mental or substance use disorders. It is the intent of the~~  
 719 | ~~legislature that a well-managed service delivery system will~~  
 720 | ~~increase access for those in need of care, improve the~~  
 721 | ~~coordination and continuity of care for vulnerable and high-risk~~  
 722 | ~~populations, and redirect service dollars from restrictive care~~  
 723 | ~~settings to community-based recovery services.~~

724 |       ~~(3)(4)~~ CONTRACT FOR SERVICES.-

725 |       ~~(a)1.~~ The department shall may contract ~~for the purchase~~  
 726 | ~~and management of behavioral health services with not-for-profit~~  
 727 | ~~community-based organizations with competence in managing~~  
 728 | networks of providers serving persons with mental health and

729 substance use disorders to serve as managing entities. However,  
 730 if fewer than two responsive bids are received to a solicitation  
 731 for a managing entity contract, the department shall reissue the  
 732 solicitation, and managed behavioral health organizations shall  
 733 also be eligible to bid and contract with the department.

734 2. The department shall require all contractors serving as  
 735 managing entities to operate under the same data reporting,  
 736 administrative, and administrative rate requirements, regardless  
 737 of whether the managing entity is for profit or not for profit  
 738 ~~The department may require a managing entity to contract for~~  
 739 ~~specialized services that are not currently part of the managing~~  
 740 ~~entity's network if the department determines that to do so is~~  
 741 ~~in the best interests of consumers of services. The secretary~~  
 742 ~~shall determine the schedule for phasing in contracts with~~  
 743 ~~managing entities. The managing entities shall, at a minimum, be~~  
 744 ~~accountable for the operational oversight of the delivery of~~  
 745 ~~behavioral health services funded by the department and for the~~  
 746 ~~collection and submission of the required data pertaining to~~  
 747 ~~these contracted services.~~

748 (b) A managing entity shall serve a geographic area  
 749 designated by the department. The geographic area must be of  
 750 sufficient size in population, funding, and services and have  
 751 ~~enough public funds for behavioral health services~~ to allow for  
 752 flexibility and ~~maximum~~ efficiency.

753 (c) Duties of the managing entity include:

754 1. Serving as the leader in its geographic area in

755 providing behavioral health services and encouraging  
 756 collaboration and coordination among its provider network, local  
 757 governments, community partners, and other systems involved in  
 758 meeting the mental health and substance abuse prevention,  
 759 assessment, stabilization, treatment, and recovery support needs  
 760 of the population within its geographic area;

761 2. Assessing community needs for behavioral health  
 762 services and determining the optimal array of services to meet  
 763 those needs within available resources, including, but not  
 764 limited to, those services provided in subsection (5);

765 3. Contracting with providers to provide services to  
 766 address community needs;

767 4. Monitoring provider performance through application of  
 768 nationally recognized standards;

769 5. Collecting and reporting data, including use of a  
 770 unique identifier developed by the department to facilitate  
 771 consumer care coordination, and using such data to continually  
 772 improve the behavioral health system of care;

773 6. Facilitating effective provider relationships and  
 774 arrangements that support coordinated service delivery and  
 775 continuity of care, including relationships and arrangements  
 776 with those other systems with which individuals with behavioral  
 777 health needs interact;

778 7. Continually working independently and in collaboration  
 779 with stakeholders, including, but not limited to, local  
 780 governments, to improve access to and effectiveness, quality,

781 and outcomes of behavioral health services and the managing  
 782 entity behavioral health system of care. This work may include,  
 783 but need not be limited to, facilitating the dissemination and  
 784 use of evidence-informed practices;

785 8. Assisting local providers with securing local matching  
 786 funds, if appropriate; and

787 9. Performing administrative and fiscal management duties  
 788 necessary to comply with federal requirements for the Substance  
 789 Abuse and Mental Health Services Administration grant.

790 (d) The contract terms shall require that, when the  
 791 contractor serving as the managing entity changes, the  
 792 department shall develop and implement a transition plan that  
 793 ensures continuity of care for patients receiving behavioral  
 794 health services.

795 (e) When necessary due to contract termination or the  
 796 expiration of the allowable contract term, the department shall  
 797 issue an invitation to negotiate in order to select an  
 798 organization to serve as a managing entity pursuant to paragraph  
 799 (a). The department shall consider the input and recommendations  
 800 of the provider network and community stakeholders when  
 801 selecting a new contractor. The invitation to negotiate shall  
 802 specify the criteria and the relative weight of the criteria  
 803 that will be used to select the new contractor. The department  
 804 must consider the contractor's:

805 1. Experience serving persons with mental health and  
 806 substance use disorders.

807        2. Established community partnerships with behavioral  
 808 health providers.

809        3. Demonstrated organizational capabilities for network  
 810 management functions.

811        4. Capability to coordinate behavioral health with primary  
 812 care services.

813        ~~(b) The operating costs of the managing entity contract~~  
 814 ~~shall be funded through funds from the department and any~~  
 815 ~~savings and efficiencies achieved through the implementation of~~  
 816 ~~managing entities when realized by their participating provider~~  
 817 ~~network agencies. The department recognizes that managing~~  
 818 ~~entities will have infrastructure development costs during~~  
 819 ~~start-up so that any efficiencies to be realized by providers~~  
 820 ~~from consolidation of management functions, and the resulting~~  
 821 ~~savings, will not be achieved during the early years of~~  
 822 ~~operation. The department shall negotiate a reasonable and~~  
 823 ~~appropriate administrative cost rate with the managing entity.~~  
 824 ~~The Legislature intends that reduced local and state contract~~  
 825 ~~management and other administrative duties passed on to the~~  
 826 ~~managing entity allows funds previously allocated for these~~  
 827 ~~purposes to be proportionately reduced and the savings used to~~  
 828 ~~purchase the administrative functions of the managing entity.~~  
 829 ~~Policies and procedures of the department for monitoring~~  
 830 ~~contracts with managing entities shall include provisions for~~  
 831 ~~eliminating duplication of the department's and the managing~~  
 832 ~~entities' contract management and other administrative~~

833 ~~activities in order to achieve the goals of cost-effectiveness~~  
834 ~~and regulatory relief. To the maximum extent possible, provider-~~  
835 ~~monitoring activities shall be assigned to the managing entity.~~

836 ~~(c) Contracting and payment mechanisms for services must~~  
837 ~~promote clinical and financial flexibility and responsiveness~~  
838 ~~and must allow different categorical funds to be integrated at~~  
839 ~~the point of service. The contracted service array must be~~  
840 ~~determined by using public input, needs assessment, and~~  
841 ~~evidence-based and promising best practice models. The~~  
842 ~~department may employ care management methodologies, prepaid~~  
843 ~~capitation, and case rate or other methods of payment which~~  
844 ~~promote flexibility, efficiency, and accountability.~~

845 ~~(4)(5) GOALS.—The department must develop and enforce~~  
846 ~~measureable outcome standards that address the following goals~~  
847 ~~goal of the service delivery strategies is to provide a design~~  
848 ~~for an effective coordination, integration, and management~~  
849 ~~approach for delivering effective behavioral health services to~~  
850 ~~persons who are experiencing a mental health or substance abuse~~  
851 ~~crisis, who have a disabling mental illness or a substance use~~  
852 ~~or co-occurring disorder, and require extended services in order~~  
853 ~~to recover from their illness, or who need brief treatment or~~  
854 ~~longer-term supportive interventions to avoid a crisis or~~  
855 ~~disability. Other goals include:~~

856 ~~(a) The provider network in the region shall deliver~~  
857 ~~effective, quality services that are evidence-informed,~~  
858 ~~coordinated, and integrated with programs such as vocational~~

859 | rehabilitation, education, child welfare, juvenile justice, and  
 860 | criminal justice, and coordinated with primary care services.

861 | (b) The scope of the behavioral health system of care as  
 862 | provided in subsection (5) shall be continually enhanced as  
 863 | resources become available.

864 | (c)(a) Behavioral health services shall be accountable to  
 865 | the public and responsive to local needs ~~Improving~~  
 866 | ~~accountability for a local system of behavioral health care~~  
 867 | ~~services to meet performance outcomes and standards through the~~  
 868 | ~~use of reliable and timely data.~~

869 | (d)(b) Interactions and relationships among members of the  
 870 | provider network shall be supported and facilitated by the  
 871 | managing entity through such means as the sharing of data and  
 872 | information in order to effectively coordinate services and  
 873 | provide continuity of care for priority populations ~~Enhancing~~  
 874 | ~~the continuity of care for all children, adolescents, and adults~~  
 875 | ~~who enter the publicly funded behavioral health service system.~~

876 | ~~(e) Preserving the "safety net" of publicly funded~~  
 877 | ~~behavioral health services and providers, and recognizing and~~  
 878 | ~~ensuring continued local contributions to these services, by~~  
 879 | ~~establishing locally designed and community-monitored systems of~~  
 880 | ~~care.~~

881 | ~~(d) Providing early diagnosis and treatment interventions~~  
 882 | ~~to enhance recovery and prevent hospitalization.~~

883 | ~~(e) Improving the assessment of local needs for behavioral~~  
 884 | ~~health services.~~

885 ~~(f) Improving the overall quality of behavioral health~~  
 886 ~~services through the use of evidence-based, best practice, and~~  
 887 ~~promising practice models.~~

888 ~~(g) Demonstrating improved service integration between~~  
 889 ~~behavioral health programs and other programs, such as~~  
 890 ~~vocational rehabilitation, education, child welfare, primary~~  
 891 ~~health care, emergency services, juvenile justice, and criminal~~  
 892 ~~justice.~~

893 ~~(h) Providing for additional testing of creative and~~  
 894 ~~flexible strategies for financing behavioral health services to~~  
 895 ~~enhance individualized treatment and support services.~~

896 ~~(i) Promoting cost-effective quality care.~~

897 ~~(j) Working with the state to coordinate admissions and~~  
 898 ~~discharges from state civil and forensic hospitals and~~  
 899 ~~coordinating admissions and discharges from residential~~  
 900 ~~treatment centers.~~

901 ~~(k) Improving the integration, accessibility, and~~  
 902 ~~dissemination of behavioral health data for planning and~~  
 903 ~~monitoring purposes.~~

904 ~~(l) Promoting specialized behavioral health services to~~  
 905 ~~residents of assisted living facilities.~~

906 ~~(m) Working with the state and other stakeholders to~~  
 907 ~~reduce the admissions and the length of stay for dependent~~  
 908 ~~children in residential treatment centers.~~

909 ~~(n) Providing services to adults and children with co-~~  
 910 ~~occurring disorders of mental illnesses and substance abuse~~

911 ~~problems.~~

912 ~~(e) Providing services to elder adults in crisis or at~~  
 913 ~~risk for placement in a more restrictive setting due to a~~  
 914 ~~serious mental illness or substance abuse.~~

915 ~~(5)(6) BEHAVIORAL HEALTH SYSTEM OF CARE ESSENTIAL~~  
 916 ~~ELEMENTS. It is the intent of the Legislature that the~~  
 917 ~~department may plan for and enter into contracts with managing~~  
 918 ~~entities to manage care in geographical areas throughout the~~  
 919 ~~state.~~

920 (a) A behavioral health system of care shall include the  
 921 following elements, which may be funded by the managing entity  
 922 to the extent allowed by resources or by other entities:

923 1. A coordinated receiving system. The goal of the  
 924 coordinated receiving system is to provide the most effective  
 925 and timely care to the greatest number of individuals. The  
 926 system shall consist of providers and entities involved in  
 927 addressing acute behavioral health care needs, including, but  
 928 not limited to, a central receiving facility, if one exists, or  
 929 other facilities performing acute behavioral health care  
 930 triaging functions for the community, crisis stabilization  
 931 units, detoxification units, addiction receiving facilities,  
 932 hospitals, and law enforcement agencies serving the county,  
 933 which have written agreements and systemwide operational  
 934 policies documenting their provision of coordinated methods of  
 935 triage, diversion, and acute behavioral health care.

936 2. Case management.

937 3. Consumer care coordination. To the extent allowed by  
 938 available resources, the managing entity shall provide for  
 939 consumer care coordination to facilitate the appropriate  
 940 delivery of behavioral health care services in the least  
 941 restrictive setting based on standardized level of care  
 942 determinations, recommendations by a treating practitioner, and  
 943 the needs of the consumer and his or her family, as appropriate.  
 944 In addition to treatment services, consumer care coordination  
 945 shall address the recovery support needs of the consumer and  
 946 shall involve coordination with other local systems and  
 947 entities, public and private, which are involved with the  
 948 consumer, such as primary health care, child welfare, behavioral  
 949 health care, and criminal and juvenile justice organizations.  
 950 Consumer care coordination shall be provided to populations in  
 951 the following order of priority:

952 a.(I) Individuals with serious mental illness or substance  
 953 use disorders who have experienced multiple arrests, involuntary  
 954 commitments, admittances to a state mental health treatment  
 955 facility, or episodes of incarceration or have been placed on  
 956 conditional release for a felony or violated a condition of  
 957 probation multiple times as a result of their behavioral health  
 958 condition.

959 (II) Individuals in state treatment facilities who are on  
 960 the wait list for community-based care.

961 b.(I) Individuals in receiving facilities or crisis  
 962 stabilization units who are on the wait list for a state

963 treatment facility.

964 (II) Children who are involved in the child welfare system  
 965 but are not in out-of-home care, except that the community-based  
 966 care lead agency shall remain responsible for services required  
 967 pursuant to s. 409.988.

968 (III) Parents or caretakers of children who are involved  
 969 in the child welfare system and individuals who account for a  
 970 disproportionate amount of behavioral health expenditures.

971 c. Other individuals eligible for services.

972 4. Outpatient services.

973 5. Residential services.

974 6. Hospital inpatient care.

975 7. Aftercare and other postdischarge services.

976 8. Recovery support, including, but not limited to,  
 977 support for competitive employment, educational attainment,  
 978 independent living skills development, family support and  
 979 education, wellness management and self-care, and assistance in  
 980 obtaining housing that meets the individual's needs. Such  
 981 housing shall include mental health residential treatment  
 982 facilities, limited mental health assisted living facilities,  
 983 adult family care homes, and supportive housing. Housing  
 984 provided using state funds must provide a safe and decent  
 985 environment free from abuse and neglect. The care plan shall  
 986 assign specific responsibility for initial and ongoing  
 987 evaluation of the supervision and support needs of the  
 988 individual and the identification of housing that meets such

989 needs. For purposes of this subparagraph, the term "supervision"  
 990 means oversight of and assistance with compliance with the  
 991 clinical aspects of an individual's care plan.

992 9. Medical services necessary for coordination of  
 993 behavioral health services with primary care.

994 10. Prevention and outreach services.

995 11. Medication-assisted treatment. The managing entity  
 996 must demonstrate the ability of its network of providers to  
 997 comply with the pertinent provisions of this chapter and chapter  
 998 397 and to ensure the provision of comprehensive behavioral  
 999 health services. The network of providers must include, but need  
 1000 not be limited to, community mental health agencies, substance  
 1001 abuse treatment providers, and best practice consumer services  
 1002 providers.

1003 ~~(b) The department shall terminate its mental health or~~  
 1004 ~~substance abuse provider contracts for services to be provided~~  
 1005 ~~by the managing entity at the same time it contracts with the~~  
 1006 ~~managing entity.~~

1007 ~~(c) The managing entity shall ensure that its provider~~  
 1008 ~~network is broadly conceived. All mental health or substance~~  
 1009 ~~abuse treatment providers currently under contract with the~~  
 1010 ~~department shall be offered a contract by the managing entity.~~

1011 ~~(d) The department may contract with managing entities to~~  
 1012 ~~provide the following core functions:~~

1013 ~~1. Financial accountability.~~

1014 ~~2. Allocation of funds to network providers in a manner~~

1015 ~~that reflects the department's strategic direction and plans.~~  
 1016 ~~3. Provider monitoring to ensure compliance with federal~~  
 1017 ~~and state laws, rules, and regulations.~~  
 1018 ~~4. Data collection, reporting, and analysis.~~  
 1019 ~~5. Operational plans to implement objectives of the~~  
 1020 ~~department's strategic plan.~~  
 1021 ~~6. Contract compliance.~~  
 1022 ~~7. Performance management.~~  
 1023 ~~8. Collaboration with community stakeholders, including~~  
 1024 ~~local government.~~  
 1025 ~~9. System of care through network development.~~  
 1026 ~~10. Consumer care coordination.~~  
 1027 ~~11. Continuous quality improvement.~~  
 1028 ~~12. Timely access to appropriate services.~~  
 1029 ~~13. Cost effectiveness and system improvements.~~  
 1030 ~~14. Assistance in the development of the department's~~  
 1031 ~~strategic plan.~~  
 1032 ~~15. Participation in community, circuit, regional, and~~  
 1033 ~~state planning.~~  
 1034 ~~16. Resource management and maximization, including~~  
 1035 ~~pursuit of third party payments and grant applications.~~  
 1036 ~~17. Incentives for providers to improve quality and~~  
 1037 ~~access.~~  
 1038 ~~18. Liaison with consumers.~~  
 1039 ~~19. Community needs assessment.~~  
 1040 ~~20. Securing local matching funds.~~

1041        (b) ~~(e)~~ The managing entity shall ensure that written  
 1042 cooperative agreements are developed and implemented among the  
 1043 criminal and juvenile justice systems, the local community-based  
 1044 care network, and the local behavioral health providers in the  
 1045 geographic area which define strategies and alternatives for  
 1046 diverting people who have mental illness and substance abuse  
 1047 problems from the criminal justice system to the community.  
 1048 These agreements must also address the provision of appropriate  
 1049 services to persons who have behavioral health problems and  
 1050 leave the criminal justice system. The managing entity shall  
 1051 work with the civil court system to develop procedures for the  
 1052 evaluation and use of involuntary outpatient placement for  
 1053 individuals as a strategy to divert future admissions to acute  
 1054 levels of care, jails, prisons, and forensic facilities, subject  
 1055 to the availability of funding for such services.

1056        (c) The managing entity shall enter into cooperative  
 1057 agreements with local homeless councils and organizations to  
 1058 allow the sharing of available resource information, shared  
 1059 client information, client referral services, and any other data  
 1060 or information that may be useful in addressing the homelessness  
 1061 of persons suffering from a behavioral health crisis.

1062        (d) ~~(f)~~ Managing entities must collect and submit data to  
 1063 the department regarding persons served, outcomes of persons  
 1064 served, ~~and the~~ costs of services provided through the  
 1065 department's contract, and other data as required by the  
 1066 department. The department shall evaluate managing entity

1067 services and the overall progress made by the managing entity,  
 1068 together with other systems, in meeting the community's  
 1069 behavioral health needs, based on consumer-centered outcome  
 1070 measures that reflect national standards, if possible, and that  
 1071 can dependably be measured. The department shall work with  
 1072 managing entities to establish performance standards related to:  
 1073 1. The extent to which individuals in the community  
 1074 receive services.  
 1075 2. The improvement in the overall behavioral health of a  
 1076 community.  
 1077 3. The improvement in functioning or progress in the  
 1078 recovery of individuals served through care coordination, as  
 1079 determined using person-centered measures tailored to the  
 1080 population ~~of quality of care for individuals served.~~  
 1081 ~~4.3.~~ The success of strategies to divert admissions to  
 1082 acute levels of care, jails, prisons, and forensic facilities as  
 1083 measured by, at a minimum, the total number and percentage of  
 1084 clients who, during a specified period, experience multiple  
 1085 admissions to acute levels of care, jails, prisons, or forensic  
 1086 facilities ~~jail, prison, and forensic facility admissions.~~  
 1087 ~~5.4.~~ Consumer and family satisfaction.  
 1088 ~~6.5.~~ The satisfaction of key community constituents such  
 1089 as law enforcement agencies, juvenile justice agencies, the  
 1090 courts, the schools, local government entities, hospitals, and  
 1091 others as appropriate for the geographical area of the managing  
 1092 entity.

1093 ~~(g) The Agency for Health Care Administration may~~  
 1094 ~~establish a certified match program, which must be voluntary.~~  
 1095 ~~Under a certified match program, reimbursement is limited to the~~  
 1096 ~~federal Medicaid share to Medicaid-enrolled strategy~~  
 1097 ~~participants. The agency may take no action to implement a~~  
 1098 ~~certified match program unless the consultation provisions of~~  
 1099 ~~chapter 216 have been met. The agency may seek federal waivers~~  
 1100 ~~that are necessary to implement the behavioral health service~~  
 1101 ~~delivery strategies.~~

1102 (6)~~(7)~~ MANAGING ENTITY REQUIREMENTS.—The department may  
 1103 adopt rules and contractual standards relating to ~~and a process~~  
 1104 ~~for~~ the qualification and operation of managing entities which  
 1105 are based, in part, on the following criteria:

1106 (a) By September 30, 2016, for managing entities under  
 1107 contract as of July 1, 2016, and within 3 months after the  
 1108 execution of the contract for managing entities procured after  
 1109 July 1, 2016, the department must verify:

1110 1. If the managing entity is not a managed behavioral  
 1111 health organization, that the entity's governing board is A  
 1112 ~~managing entity's governance structure shall be~~ representative  
 1113 of and ~~shall~~, at a minimum, includes ~~include~~ consumers and  
 1114 family members, local governments, area law enforcement  
 1115 agencies, business leaders, appropriate community stakeholders  
 1116 ~~and organizations,~~ and providers of substance abuse and mental  
 1117 health services as defined in this chapter and chapter 397,  
 1118 community-based care lead agency representatives, and health

1119 care facility representatives. The managing entity must create a  
 1120 transparent process for the nomination and selection of board  
 1121 members and must adopt a procedure for establishing the  
 1122 staggered terms of board members.

1123 2. If the managing entity is a managed behavioral health  
 1124 organization, that the entity establishes an advisory board that  
 1125 meets the same requirements as the governing board in  
 1126 subparagraph 1. The duties of the advisory board shall include,  
 1127 but are not limited to, making recommendations to the department  
 1128 about the renewal of the managing entity contract or the award  
 1129 of a new contract to the managing entity ~~If there are one or~~  
 1130 ~~more private receiving facilities in the geographic coverage~~  
 1131 ~~area of a managing entity, the managing entity shall have one~~  
 1132 ~~representative for the private receiving facilities as an ex~~  
 1133 ~~officio member of its board of directors.~~

1134 ~~(b) A managing entity that was originally formed primarily~~  
 1135 ~~by substance abuse or mental health providers must present and~~  
 1136 ~~demonstrate a detailed, consensus approach to expanding its~~  
 1137 ~~provider network and governance to include both substance abuse~~  
 1138 ~~and mental health providers.~~

1139 (b)(e) A managing entity must submit a network management  
 1140 plan and budget in a form and manner determined by the  
 1141 department. ~~The plan must detail the means for implementing the~~  
 1142 ~~duties to be contracted to the managing entity and the~~  
 1143 ~~efficiencies to be anticipated by the department as a result of~~  
 1144 ~~executing the contract.~~ The department may require modifications

1145 to the plan and must approve the plan before contracting with a  
1146 managing entity.

1147 1. Provider participation in the network is subject to  
1148 credentials and performance standards set by the managing  
1149 entity. The department may not require the managing entity to  
1150 conduct provider network procurements in order to select  
1151 providers. However, the managing entity shall establish a  
1152 process for publicizing opportunities to participate in its  
1153 network, evaluating new participants for inclusion in its  
1154 network, and evaluating current providers to determine whether  
1155 they should remain network participants. This process shall be  
1156 posted on the managing entity's website.

1157 2. The network management plan and provider contracts  
1158 shall, at a minimum, provide for managing entity and provider  
1159 involvement to ensure continuity of care for clients if a  
1160 provider ceases to provide a service or leaves the network ~~The~~  
1161 ~~department may contract with a managing entity that demonstrates~~  
1162 ~~readiness to assume core functions, and may continue to add~~  
1163 ~~functions and responsibilities to the managing entity's contract~~  
1164 ~~over time as additional competencies are developed as identified~~  
1165 ~~in paragraph (g). Notwithstanding other provisions of this~~  
1166 ~~section, the department may continue and expand managing entity~~  
1167 ~~contracts if the department determines that the managing entity~~  
1168 ~~meets the requirements specified in this section.~~

1169 ~~(d) Notwithstanding paragraphs (b) and (c), a managing~~  
1170 ~~entity that is currently a fully integrated system providing~~

1171 ~~mental health and substance abuse services, Medicaid, and child~~  
 1172 ~~welfare services is permitted to continue operating under its~~  
 1173 ~~current governance structure as long as the managing entity can~~  
 1174 ~~demonstrate to the department that consumers, other~~  
 1175 ~~stakeholders, and network providers are included in the planning~~  
 1176 ~~process.~~

1177 (c)~~(e)~~ Managing entities shall operate in a transparent  
 1178 manner, providing public access to information, notice of  
 1179 meetings, and opportunities for broad public participation in  
 1180 decisionmaking. The managing entity's network management plan  
 1181 must detail policies and procedures that ensure transparency.

1182 (d)~~(f)~~ Before contracting with a managing entity, the  
 1183 department must perform an onsite readiness review of a managing  
 1184 entity to determine its operational capacity to satisfactorily  
 1185 perform the duties to be contracted.

1186 (e)~~(g)~~ The department shall engage community stakeholders,  
 1187 including providers and managing entities under contract with  
 1188 the department, in the development of objective standards to  
 1189 measure the competencies of managing entities and their  
 1190 readiness to assume the responsibilities described in this  
 1191 section, and the outcomes to hold them accountable.

1192 (7) COORDINATED BEHAVIORAL HEALTH SYSTEM OF CARE  
 1193 DESIGNATION AND COMMUNITY PLANNING.—

1194 (a)1. Managing entities may earn the coordinated  
 1195 behavioral health system of care designation by developing and  
 1196 implementing plans to facilitate their network providers in

1197 working together seamlessly with each other, their community  
1198 partners, and systems, such as the child welfare system, the  
1199 criminal justice system, and the Medicaid program, to use  
1200 resources in a highly cost-effective manner to improve outcomes  
1201 for individuals with mental illness and substance use disorders  
1202 and enhance the overall behavioral health of the community.

1203 2. Managing entities shall develop the plans in a  
1204 collaborative manner, and all such entities licensed or funded  
1205 by the department, licensed or funded by the Agency for Health  
1206 Care Administration, or funded or operated by the Department of  
1207 Health shall cooperate with the development and implementation  
1208 of the plans, as requested by the managing entity. The plans  
1209 shall, at a minimum, involve the implementation of written  
1210 agreements that define common protocols for intake and  
1211 assessment, create methods of data and information sharing,  
1212 institute joint operational procedures, provide for integrated  
1213 care planning and case management, and initiate cooperative  
1214 evaluation procedures. The plans shall address coordination  
1215 within and between the following major subsystems within the  
1216 behavioral health system of care, by subregion, if appropriate:

1217 a. Prevention and diversion.  
1218 b. Coordinated receiving system or systems as provided in  
1219 subparagraph (5)(a)1. The managing entity shall include all  
1220 appropriate providers and systems involved in addressing the  
1221 county's acute behavioral health care needs in the planning  
1222 activities relating to the coordinated receiving system or

1223 systems.  
 1224 c. Treatment and recovery support.  
 1225 3. The plans shall also address coordination between the  
 1226 behavioral health system of care and systems, such as the child  
 1227 welfare system, the criminal justice system, and the Medicaid  
 1228 program.  
 1229 (b) For managing entities under contract as of July 1,  
 1230 2016:  
 1231 1. By November 30, 2016, the department must define the  
 1232 measurable minimum standards for a managing entity to earn the  
 1233 coordinated behavioral health system of care designation.  
 1234 2. By June 30, 2017, each managing entity must submit its  
 1235 plans to the department for earning the coordinated behavioral  
 1236 health system of care designation. Each plan shall provide an  
 1237 assessment of the current status of the managing entity's  
 1238 behavioral health system of care by subsystem identified in  
 1239 subparagraph (a)2. and as a full system, and by subregion, and  
 1240 describe the strategies, action steps, timelines, and measurable  
 1241 standards for earning such designation. The department may  
 1242 request revisions to managing entities' plans but must approve  
 1243 such revisions by September 30, 2017. By September 30, 2018, and  
 1244 September 30, 2019, the managing entity shall provide an update  
 1245 to its plans depicting its current status and progress during  
 1246 the previous fiscal year to the department. The department shall  
 1247 provide all final plans and updates by October 5, 2019, to the  
 1248 Governor, the President of the Senate, and the Speaker of the

1249 House of Representatives.

1250 3. By October 31, 2019, the department must determine  
 1251 whether the managing entity has earned the coordinated  
 1252 behavioral health system of care designation. Notwithstanding  
 1253 chapter 287, the department may renew the contract of a managing  
 1254 entity that earns the coordinated behavioral health system of  
 1255 care designation within the required timeframe even if the  
 1256 contract provisions do not allow an additional renewal, provided  
 1257 other contract requirements and performance standards are met.

1258 (c) Managing entities whose initial contract with the  
 1259 state is executed after July 1, 2016, must earn the coordinated  
 1260 behavioral health system of care designation within 3 years  
 1261 after the contract execution date. The managing entity shall  
 1262 submit plans and reports on its current status and progress in  
 1263 earning this designation as required by the department.  
 1264 Notwithstanding chapter 287, the department may renew the  
 1265 contract of a managing entity that earns the coordinated  
 1266 behavioral health system of care designation within the required  
 1267 timeframe even if the contract provisions do not allow an  
 1268 additional renewal, provided other contract requirements and  
 1269 performance standards are met.

1270 (d) After earning the coordinated behavioral health system  
 1271 of care designation, the managing entity must maintain this  
 1272 designation by documenting the ongoing use and continuous  
 1273 improvement of the coordination methods specified in the written  
 1274 agreements.

1275 (e) By February 1 of each year, beginning in 2018, each  
 1276 managing entity shall develop and submit to the department a  
 1277 plan for phased enhancement of the subsystems described in  
 1278 subparagraph (a)2., by subregion of the managing entity's  
 1279 service area, if appropriate, based on the assessed behavioral  
 1280 health care needs of the subregion and system gaps. If the plan  
 1281 recommends additional funding, for each recommended use of funds  
 1282 the enhancement plan must describe, at a minimum, the specific  
 1283 needs that would be met, the specific services that would be  
 1284 purchased, the estimated benefits of the services, the projected  
 1285 costs, the projected number of individuals that would be served,  
 1286 and any other information indicating the estimated benefit to  
 1287 the community. The managing entity shall include consumers and  
 1288 their family members, local governments, law enforcement  
 1289 agencies, providers, community partners, and other stakeholders  
 1290 when developing the plan. Individual sections of the plan shall  
 1291 address:

1292 1. The acute behavioral health care subsystem, and shall  
 1293 give consideration to evidence-based, evidence-informed, and  
 1294 innovative practices for diverting individuals from the acute  
 1295 behavioral health care system and addressing their needs once  
 1296 they are in the system in the most efficient and cost-effective  
 1297 manner.

1298 2. The treatment and recovery support subsystem and shall  
 1299 emphasize the provision of care coordination to priority  
 1300 populations and the use of recovery-oriented, peer-involved

1301 approaches.

1302 3. Coordination between the behavioral health system of  
 1303 care and other systems and shall give consideration to  
 1304 approaches to enhancing such coordination.

1305 ~~(8) DEPARTMENT RESPONSIBILITIES. With the introduction of~~  
 1306 ~~managing entities to monitor department contracted providers'~~  
 1307 ~~day to day operations, the department and its regional and~~  
 1308 ~~circuit offices will have increased ability to focus on broad~~  
 1309 ~~systemic substance abuse and mental health issues. After the~~  
 1310 ~~department enters into a managing entity contract in a~~  
 1311 ~~geographic area, the regional and circuit offices of the~~  
 1312 ~~department in that area shall direct their efforts primarily to~~  
 1313 ~~monitoring the managing entity contract, including negotiation~~  
 1314 ~~of system quality improvement goals each contract year, and~~  
 1315 ~~review of the managing entity's plans to execute department~~  
 1316 ~~strategic plans; carrying out statutorily mandated licensure~~  
 1317 ~~functions; conducting community and regional substance abuse and~~  
 1318 ~~mental health planning; communicating to the department the~~  
 1319 ~~local needs assessed by the managing entity; preparing~~  
 1320 ~~department strategic plans; coordinating with other state and~~  
 1321 ~~local agencies; assisting the department in assessing local~~  
 1322 ~~trends and issues and advising departmental headquarters on~~  
 1323 ~~local priorities; and providing leadership in disaster planning~~  
 1324 ~~and preparation.~~

1325 (8)(9) FUNDING FOR MANAGING ENTITIES.-

1326 (a) A contract established between the department and a

1327 | managing entity under this section shall be funded by general  
 1328 | revenue, other applicable state funds, or applicable federal  
 1329 | funding sources. A managing entity may carry forward documented  
 1330 | unexpended state funds from one fiscal year to the next;  
 1331 | however, the cumulative amount carried forward may not exceed 8  
 1332 | percent of the total contract. Any unexpended state funds in  
 1333 | excess of that percentage must be returned to the department.  
 1334 | The funds carried forward may not be used in a way that would  
 1335 | create increased recurring future obligations or for any program  
 1336 | or service that is not currently authorized under the existing  
 1337 | contract with the department. Expenditures of funds carried  
 1338 | forward must be separately reported to the department. Any  
 1339 | unexpended funds that remain at the end of the contract period  
 1340 | shall be returned to the department. Funds carried forward may  
 1341 | be retained through contract renewals and new procurements as  
 1342 | long as the same managing entity is retained by the department.

1343 |       (b) The method of payment for a fixed-price contract with  
 1344 | a managing entity must provide for a 2-month advance payment at  
 1345 | the beginning of each fiscal year and equal monthly payments  
 1346 | thereafter.

1347 |       (9)~~(10)~~ CRISIS STABILIZATION SERVICES UTILIZATION  
 1348 | DATABASE.—The department shall develop, implement, and maintain  
 1349 | standards under which a managing entity shall collect  
 1350 | utilization data from all public receiving facilities situated  
 1351 | within its geographic service area. As used in this subsection,  
 1352 | the term "public receiving facility" means an entity that meets

1353 the licensure requirements of and is designated by the  
 1354 department to operate as a public receiving facility under s.  
 1355 394.875 and that is operating as a licensed crisis stabilization  
 1356 unit.

1357 (a) The department shall develop standards and protocols  
 1358 for managing entities and public receiving facilities to be used  
 1359 for data collection, storage, transmittal, and analysis. The  
 1360 standards and protocols must allow for compatibility of data and  
 1361 data transmittal between public receiving facilities, managing  
 1362 entities, and the department for the implementation and  
 1363 requirements of this subsection. ~~The department shall require~~  
 1364 ~~managing entities contracted under this section to comply with~~  
 1365 ~~this subsection by August 1, 2015.~~

1366 (b) A managing entity shall require a public receiving  
 1367 facility within its provider network to submit data, in real  
 1368 time or at least daily, to the managing entity for:

1369 1. All admissions and discharges of clients receiving  
 1370 public receiving facility services who qualify as indigent, as  
 1371 defined in s. 394.4787; and

1372 2. Current active census of total licensed beds, the  
 1373 number of beds purchased by the department, the number of  
 1374 clients qualifying as indigent occupying those beds, and the  
 1375 total number of unoccupied licensed beds regardless of funding.

1376 (c) A managing entity shall require a public receiving  
 1377 facility within its provider network to submit data, on a  
 1378 monthly basis, to the managing entity which aggregates the daily

1379 data submitted under paragraph (b). The managing entity shall  
 1380 reconcile the data in the monthly submission to the data  
 1381 received by the managing entity under paragraph (b) to check for  
 1382 consistency. If the monthly aggregate data submitted by a public  
 1383 receiving facility under this paragraph is inconsistent with the  
 1384 daily data submitted under paragraph (b), the managing entity  
 1385 shall consult with the public receiving facility to make  
 1386 corrections as necessary to ensure accurate data.

1387 (d) A managing entity shall require a public receiving  
 1388 facility within its provider network to submit data, on an  
 1389 annual basis, to the managing entity which aggregates the data  
 1390 submitted and reconciled under paragraph (c). The managing  
 1391 entity shall reconcile the data in the annual submission to the  
 1392 data received and reconciled by the managing entity under  
 1393 paragraph (c) to check for consistency. If the annual aggregate  
 1394 data submitted by a public receiving facility under this  
 1395 paragraph is inconsistent with the data received and reconciled  
 1396 under paragraph (c), the managing entity shall consult with the  
 1397 public receiving facility to make corrections as necessary to  
 1398 ensure accurate data.

1399 (e) After ensuring accurate data under paragraphs (c) and  
 1400 (d), the managing entity shall submit the data to the department  
 1401 on a monthly and an annual basis. The department shall create a  
 1402 statewide database for the data described under paragraph (b)  
 1403 and submitted under this paragraph for the purpose of analyzing  
 1404 the payments for and the use of crisis stabilization services

1405 funded by the Baker Act on a statewide basis and on an  
 1406 individual public receiving facility basis.

1407 (f) The department shall adopt rules to administer this  
 1408 subsection.

1409 (g) The department shall submit a report by January 31,  
 1410 2016, and annually thereafter, to the Governor, the President of  
 1411 the Senate, and the Speaker of the House of Representatives  
 1412 which provides details on the implementation of this subsection,  
 1413 including the status of the data collection process and a  
 1414 detailed analysis of the data collected under this subsection.

1415 ~~(11) REPORTING. Reports of the department's activities,~~  
 1416 ~~progress, and needs in achieving the goal of contracting with~~  
 1417 ~~managing entities in each circuit and region statewide must be~~  
 1418 ~~submitted to the appropriate substantive and appropriations~~  
 1419 ~~committees in the Senate and the House of Representatives on~~  
 1420 ~~January 1 and July 1 of each year until the full transition to~~  
 1421 ~~managing entities has been accomplished statewide.~~

1422 (10)~~(12)~~ RULES.—The department may ~~shall~~ adopt rules to  
 1423 administer this section ~~and, as necessary, to further specify~~  
 1424 ~~requirements of managing entities.~~

1425 Section 9. Subsections (20) through (45) of section  
 1426 397.311, Florida Statutes, are renumbered as subsections (21)  
 1427 through (46), respectively, present subsection (38) is amended,  
 1428 and a new subsection (20) is added to that section, to read:

1429 397.311 Definitions.—As used in this chapter, except part  
 1430 VIII, the term:

1431           (20) "Informed consent" means consent voluntarily given in  
 1432 writing, by a competent person, after sufficient explanation and  
 1433 disclosure of the subject matter involved to enable the person  
 1434 to make a knowing and willful decision without any element of  
 1435 force, fraud, deceit, duress, or other form of constraint or  
 1436 coercion.

1437           (39)~~(38)~~ "Service component" or "component" means a  
 1438 discrete operational entity within a service provider which is  
 1439 subject to licensing as defined by rule. Service components  
 1440 include prevention, intervention, and clinical treatment  
 1441 described in subsection (23) ~~(22)~~.

1442           Section 10. Subsections (4) through (14) of section  
 1443 397.321, Florida Statutes, are renumbered as subsections (5)  
 1444 through (15), respectively, present subsection (15) is amended,  
 1445 and new subsections (4) and (21) are added to that section, to  
 1446 read:

1447           397.321 Duties of the department.—The department shall:

1448           (4) Develop, implement, and maintain standards under which  
 1449 a managing entity shall collect from detoxification and  
 1450 addictions receiving facilities under contract with the managing  
 1451 entity utilization data relating to substance abuse services  
 1452 provided pursuant to parts IV and V of this chapter. The  
 1453 standards must allow for data compatibility and data transmittal  
 1454 between licensed service providers, managing entities, and the  
 1455 department. The department shall require managing entities  
 1456 contracted under this section to comply with this subsection by

1457 August 1, 2016.

1458 (a) A managing entity shall require a licensed service  
 1459 provider to submit client-specific data, in real time or at  
 1460 least daily, to the managing entity regarding:

1461 1. All admissions and discharges of clients receiving  
 1462 substance abuse services in an addictions receiving facility.

1463 2. All admissions and discharges of clients receiving  
 1464 substance abuse services in a detoxification facility.

1465 (b) A managing entity shall require each licensed service  
 1466 provider to submit client-specific data, on a monthly basis, to  
 1467 the managing entity which aggregates the daily data submitted  
 1468 under paragraph (a). The managing entity shall reconcile the  
 1469 monthly data submitted under this paragraph to the daily data  
 1470 submitted under paragraph (a) to check for consistency. If the  
 1471 monthly aggregate data is inconsistent with the daily data, the  
 1472 managing entity shall consult with the licensed service provider  
 1473 to make corrections as necessary to ensure the data's accuracy.

1474 (c) A managing entity shall require the appropriate  
 1475 service provider to submit data, on an annual basis, to the  
 1476 department which aggregates the data submitted under paragraph  
 1477 (b). The managing entity shall reconcile the annual data  
 1478 submitted under this paragraph to the monthly data submitted  
 1479 under paragraph (b) to check for consistency.

1480 (d) After ensuring that the data submitted under  
 1481 paragraphs (b) and (c) is accurate, the managing entity shall  
 1482 submit the data to the department monthly and annually. The

1483 department shall create a statewide database to store the data  
 1484 described in paragraph (a) and submitted under this paragraph  
 1485 for purposes of analyzing the payments for and the use of  
 1486 substance abuse services provided pursuant to parts IV and V of  
 1487 this chapter.

1488 (e) The department shall adopt rules to administer this  
 1489 subsection. The department shall submit a report by January 31,  
 1490 2017, and annually thereafter, to the Governor, the President of  
 1491 the Senate, and the Speaker of the House of Representatives  
 1492 which provides details on the implementation of this subsection,  
 1493 including the status of the data collection process and a  
 1494 detailed analysis of the data collected under this subsection.

1495 (21) The department shall develop and prominently display  
 1496 on its website all forms necessary for the implementation and  
 1497 administration of parts IV and V of this chapter. These forms  
 1498 shall include, but are not limited to, a petition for  
 1499 involuntary admission form and all related pleading forms, and a  
 1500 form to be used by law enforcement agencies pursuant to s.  
 1501 397.6772. The department shall notify law enforcement agencies,  
 1502 the courts, and other state agencies of the existence and  
 1503 availability of such forms.

1504 ~~(15) Appoint a substance abuse impairment coordinator to~~  
 1505 ~~represent the department in efforts initiated by the statewide~~  
 1506 ~~substance abuse impairment prevention and treatment coordinator~~  
 1507 ~~established in s. 397.801 and to assist the statewide~~  
 1508 ~~coordinator in fulfilling the responsibilities of that position.~~

1509 Section 11. Section 397.402, Florida Statutes, is created  
 1510 to read:

1511 397.402 Single, consolidated licensure.—The department and  
 1512 the Agency for Health Care Administration shall develop a plan  
 1513 for modifying licensure statutes and rules to provide options  
 1514 for a single, consolidated license for a provider that offers  
 1515 multiple types of either or both mental health and substance  
 1516 abuse services regulated under chapters 394 and 397. The plan  
 1517 shall identify options for license consolidation within the  
 1518 department and within the agency, and shall identify interagency  
 1519 license consolidation options. The department and the agency  
 1520 shall submit the plan to the Governor, the President of the  
 1521 Senate, and the Speaker of the House of Representatives by  
 1522 November 1, 2016.

1523 Section 12. Subsection (1) of section 397.6772, Florida  
 1524 Statutes, is amended to read:

1525 397.6772 Protective custody without consent.—

1526 (1) If a person in circumstances which justify protective  
 1527 custody as described in s. 397.677 fails or refuses to consent  
 1528 to assistance and a law enforcement officer has determined that  
 1529 a hospital or a licensed detoxification or addictions receiving  
 1530 facility is the most appropriate place for the person, the  
 1531 officer may, after giving due consideration to the expressed  
 1532 wishes of the person:

1533 (a) Take the person to a hospital or to a licensed  
 1534 detoxification or addictions receiving facility against the

1535 | person's will but without using unreasonable force. The officer  
 1536 | shall use the standard form developed by the department pursuant  
 1537 | to s. 397.321 to execute a written report detailing the  
 1538 | circumstances under which the person was taken into custody. The  
 1539 | written report shall be included in the patient's clinical  
 1540 | record; or

1541 |         (b) In the case of an adult, detain the person for his or  
 1542 | her own protection in any municipal or county jail or other  
 1543 | appropriate detention facility.

1544 |

1545 | Such detention is not to be considered an arrest for any  
 1546 | purpose, and no entry or other record may be made to indicate  
 1547 | that the person has been detained or charged with any crime. The  
 1548 | officer in charge of the detention facility must notify the  
 1549 | nearest appropriate licensed service provider within the first 8  
 1550 | hours after detention that the person has been detained. It is  
 1551 | the duty of the detention facility to arrange, as necessary, for  
 1552 | transportation of the person to an appropriate licensed service  
 1553 | provider with an available bed. Persons taken into protective  
 1554 | custody must be assessed by the attending physician within the  
 1555 | 72-hour period and without unnecessary delay, to determine the  
 1556 | need for further services.

1557 |         Section 13. Subsection (1) of section 397.681, Florida  
 1558 | Statutes, is amended to read:

1559 |             397.681 Involuntary petitions; general provisions; court  
 1560 | jurisdiction and right to counsel.—

1561 (1) JURISDICTION.—The courts have jurisdiction of  
 1562 involuntary assessment and stabilization petitions and  
 1563 involuntary treatment petitions for substance abuse impaired  
 1564 persons, and such petitions must be filed with the clerk of the  
 1565 court in the county where the person is located. The court may  
 1566 not charge a fee for the filing of a petition under this  
 1567 section. The chief judge may appoint a general or special  
 1568 magistrate to preside over all or part of the proceedings. The  
 1569 alleged impaired person is named as the respondent.

1570 Section 14. Section 397.6955, Florida Statutes, is amended  
 1571 to read:

1572 397.6955 Duties of court upon filing of petition for  
 1573 involuntary treatment.—Upon the filing of a petition for the  
 1574 involuntary treatment of a substance abuse impaired person with  
 1575 the clerk of the court, the court shall immediately determine  
 1576 whether the respondent is represented by an attorney or whether  
 1577 the appointment of counsel for the respondent is appropriate.  
 1578 The court shall schedule a hearing to be held on the petition  
 1579 within 10 days, unless a continuance is granted. A copy of the  
 1580 petition and notice of the hearing must be provided to the  
 1581 respondent; the respondent's parent, guardian, or legal  
 1582 custodian, in the case of a minor; the respondent's attorney, if  
 1583 known; the petitioner; the respondent's spouse or guardian, if  
 1584 applicable; and such other persons as the court may direct, and  
 1585 have such petition and order personally delivered to the  
 1586 respondent if he or she is a minor. The court shall also issue a

1587 summons to the person whose admission is sought.

1588 Section 15. Subsection (1) of section 397.697, Florida  
 1589 Statutes, is amended to read:

1590 397.697 Court determination; effect of court order for  
 1591 involuntary substance abuse treatment.—

1592 (1) When the court finds that the conditions for  
 1593 involuntary substance abuse treatment have been proved by clear  
 1594 and convincing evidence, it may order the respondent to undergo  
 1595 involuntary treatment by a licensed service provider for a  
 1596 period not to exceed 60 days. The court may order a respondent  
 1597 to undergo treatment through a privately funded licensed service  
 1598 provider if the respondent has the ability to pay for the  
 1599 treatment or if any person voluntarily demonstrates the  
 1600 willingness and ability to pay for the respondent's treatment.

1601 If the court finds it necessary, it may direct the sheriff to  
 1602 take the respondent into custody and deliver him or her to the  
 1603 licensed service provider specified in the court order, or to  
 1604 the nearest appropriate licensed service provider, for  
 1605 involuntary treatment. When the conditions justifying  
 1606 involuntary treatment no longer exist, the individual must be  
 1607 released as provided in s. 397.6971. When the conditions  
 1608 justifying involuntary treatment are expected to exist after 60  
 1609 days of treatment, a renewal of the involuntary treatment order  
 1610 may be requested pursuant to s. 397.6975 prior to the end of the  
 1611 60-day period.

1612 Section 16. Paragraphs (d) through (m) of subsection (2)

1613 of section 409.967, Florida Statutes, are redesignated as  
 1614 paragraphs (e) through (n), respectively, and a new paragraph  
 1615 (d) is added to that subsection to read:

1616 409.967 Managed care plan accountability.—

1617 (2) The agency shall establish such contract requirements  
 1618 as are necessary for the operation of the statewide managed care  
 1619 program. In addition to any other provisions the agency may deem  
 1620 necessary, the contract must require:

1621 (d) Quality care.—Managed care plans shall provide, or  
 1622 contract for the provision of, care coordination to facilitate  
 1623 the appropriate delivery of behavioral health care services in  
 1624 the least restrictive setting with treatment and recovery  
 1625 capabilities that address the needs of the patient. Services  
 1626 shall be provided in a manner that integrates behavioral health  
 1627 services and primary care services. Plans shall be required to  
 1628 achieve specific behavioral health outcome standards established  
 1629 by the agency in consultation with the department.

1630 Section 17. Subsection (5) is added to section 409.973,  
 1631 Florida Statutes, to read:

1632 409.973 Benefits.—

1633 (5) INTEGRATED BEHAVIORAL HEALTH INITIATIVE.—Each plan  
 1634 operating in the managed medical assistance program shall work  
 1635 with the managing entity in its service area to establish  
 1636 specific organizational supports and service protocols that  
 1637 enhance the integration and coordination of primary care and  
 1638 behavioral health services for Medicaid recipients. Progress in

1639 this initiative shall be measured using the integration  
 1640 framework and core measures developed by the Agency for  
 1641 Healthcare Research and Quality.

1642 Section 18. Section 491.0045, Florida Statutes is amended  
 1643 to read:

1644 491.0045 Intern registration; requirements.—

1645 (1) ~~Effective January 1, 1998,~~ An individual who has not  
 1646 satisfied ~~intends to practice in Florida to satisfy~~ the  
 1647 postgraduate or post-master's level experience requirements, as  
 1648 specified in s. 491.005(1)(c), (3)(c), or (4)(c), must register  
 1649 as an intern in the profession for which he or she is seeking  
 1650 licensure prior to commencing the post-master's experience  
 1651 requirement or an individual who intends to satisfy part of the  
 1652 required graduate-level practicum, internship, or field  
 1653 experience, outside the academic arena for any profession, must  
 1654 register as an intern in the profession for which he or she is  
 1655 seeking licensure prior to commencing the practicum, internship,  
 1656 or field experience.

1657 (2) The department shall register as a clinical social  
 1658 worker intern, marriage and family therapist intern, or mental  
 1659 health counselor intern each applicant who the board certifies  
 1660 has:

1661 (a) Completed the application form and remitted a  
 1662 nonrefundable application fee not to exceed \$200, as set by  
 1663 board rule;

1664 (b)1. Completed the education requirements as specified in

1665 s. 491.005(1)(c), (3)(c), or (4)(c) for the profession for which  
 1666 he or she is applying for licensure, if needed; and

1667 2. Submitted an acceptable supervision plan, as determined  
 1668 by the board, for meeting the practicum, internship, or field  
 1669 work required for licensure that was not satisfied in his or her  
 1670 graduate program.

1671 (c) Identified a qualified supervisor.

1672 (3) An individual registered under this section must  
 1673 remain under supervision while practicing under registered  
 1674 intern status ~~until he or she is in receipt of a license or a~~  
 1675 ~~letter from the department stating that he or she is licensed to~~  
 1676 ~~practice the profession for which he or she applied.~~

1677 ~~(4) An individual who has applied for intern registration~~  
 1678 ~~on or before December 31, 2001, and has satisfied the education~~  
 1679 ~~requirements of s. 491.005 that are in effect through December~~  
 1680 ~~31, 2000, will have met the educational requirements for~~  
 1681 ~~licensure for the profession for which he or she has applied.~~

1682 (4)(5) An individual who fails ~~Individuals who have~~  
 1683 ~~commenced the experience requirement as specified in s.~~  
 1684 ~~491.005(1)(c), (3)(c), or (4)(c) but failed to register as~~  
 1685 ~~required by subsection (1) shall register with the department~~  
 1686 ~~before January 1, 2000. Individuals who fail to comply with this~~  
 1687 section may subsection shall not be granted a license under this  
 1688 chapter, and any time spent by the individual completing the  
 1689 experience requirement as specified in s. 491.005(1)(c), (3)(c),  
 1690 or (4)(c) before ~~prior to~~ registering as an intern does shall

1691 not count toward completion of the ~~such~~ requirement.

1692 (5) An intern registration is valid for 5 years.

1693 (6) A registration issued on or before March 31, 2017,  
 1694 expires March 31, 2022, and may not be renewed or reissued. A  
 1695 registration issued after March 31, 2017, expires 60 months  
 1696 after the date it is issued. A subsequent intern registration  
 1697 may not be issued unless the candidate has passed the theory and  
 1698 practice examination described in s. 491.005(1)(d), (3)(d), and  
 1699 (4)(d).

1700 (7) An individual who has held a provisional license  
 1701 issued by the board may not apply for an intern registration in  
 1702 the same profession.

1703 Section 19. Section 394.4674, Florida Statutes, is  
 1704 repealed.

1705 Section 20. Section 394.4985, Florida Statutes, is  
 1706 repealed.

1707 Section 21. Section 394.745, Florida Statutes, is  
 1708 repealed.

1709 Section 22. Section 397.331, Florida Statutes, is  
 1710 repealed.

1711 Section 23. Section 397.801, Florida Statutes, is  
 1712 repealed.

1713 Section 24. Section 397.811, Florida Statutes, is  
 1714 repealed.

1715 Section 25. Section 397.821, Florida Statutes, is  
 1716 repealed.397

1717 Section 26. Section 397.901, Florida Statutes, is  
 1718 repealed.

1719 Section 27. Section 397.93, Florida Statutes, is repealed.

1720 Section 28. Section 397.94, Florida Statutes, is repealed.

1721 Section 29. Section 397.951, Florida Statutes, is  
 1722 repealed.

1723 Section 30. Section 397.97, Florida Statutes, is repealed.

1724 Section 31. Section 397.98, Florida Statutes, is repealed.

1725 Section 32. Paragraph (e) of subsection (5) of section  
 1726 212.055, Florida Statutes, is amended to read:

1727 212.055 Discretionary sales surtaxes; legislative intent;  
 1728 authorization and use of proceeds.—It is the legislative intent  
 1729 that any authorization for imposition of a discretionary sales  
 1730 surtax shall be published in the Florida Statutes as a  
 1731 subsection of this section, irrespective of the duration of the  
 1732 levy. Each enactment shall specify the types of counties  
 1733 authorized to levy; the rate or rates which may be imposed; the  
 1734 maximum length of time the surtax may be imposed, if any; the  
 1735 procedure which must be followed to secure voter approval, if  
 1736 required; the purpose for which the proceeds may be expended;  
 1737 and such other requirements as the Legislature may provide.  
 1738 Taxable transactions and administrative procedures shall be as  
 1739 provided in s. 212.054.

1740 (5) COUNTY PUBLIC HOSPITAL SURTAX.—Any county as defined  
 1741 in s. 125.011(1) may levy the surtax authorized in this  
 1742 subsection pursuant to an ordinance either approved by

1743 extraordinary vote of the county commission or conditioned to  
 1744 take effect only upon approval by a majority vote of the  
 1745 electors of the county voting in a referendum. In a county as  
 1746 defined in s. 125.011(1), for the purposes of this subsection,  
 1747 "county public general hospital" means a general hospital as  
 1748 defined in s. 395.002 which is owned, operated, maintained, or  
 1749 governed by the county or its agency, authority, or public  
 1750 health trust.

1751 (e) A governing board, agency, or authority shall be  
 1752 chartered by the county commission upon this act becoming law.  
 1753 The governing board, agency, or authority shall adopt and  
 1754 implement a health care plan for indigent health care services.  
 1755 The governing board, agency, or authority shall consist of no  
 1756 more than seven and no fewer than five members appointed by the  
 1757 county commission. The members of the governing board, agency,  
 1758 or authority shall be at least 18 years of age and residents of  
 1759 the county. No member may be employed by or affiliated with a  
 1760 health care provider or the public health trust, agency, or  
 1761 authority responsible for the county public general hospital.  
 1762 The following community organizations shall each appoint a  
 1763 representative to a nominating committee: the South Florida  
 1764 Hospital and Healthcare Association, the Miami-Dade County  
 1765 Public Health Trust, the Dade County Medical Association, the  
 1766 Miami-Dade County Homeless Trust, and the Mayor of Miami-Dade  
 1767 County. This committee shall nominate between 10 and 14 county  
 1768 citizens for the governing board, agency, or authority. The

1769 slate shall be presented to the county commission and the county  
 1770 commission shall confirm the top five to seven nominees,  
 1771 depending on the size of the governing board. Until such time as  
 1772 the governing board, agency, or authority is created, the funds  
 1773 provided for in subparagraph (d)2. shall be placed in a  
 1774 restricted account set aside from other county funds and not  
 1775 disbursed by the county for any other purpose.

1776 1. The plan shall divide the county into a minimum of four  
 1777 and maximum of six service areas, with no more than one  
 1778 participant hospital per service area. The county public general  
 1779 hospital shall be designated as the provider for one of the  
 1780 service areas. Services shall be provided through participants'  
 1781 primary acute care facilities.

1782 2. The plan and subsequent amendments to it shall fund a  
 1783 defined range of health care services for both indigent persons  
 1784 and the medically poor, including primary care, preventive care,  
 1785 hospital emergency room care, and hospital care necessary to  
 1786 stabilize the patient. For the purposes of this section,  
 1787 "stabilization" means stabilization as defined in s. 397.311(42)  
 1788 ~~397.311(41)~~. Where consistent with these objectives, the plan  
 1789 may include services rendered by physicians, clinics, community  
 1790 hospitals, and alternative delivery sites, as well as at least  
 1791 one regional referral hospital per service area. The plan shall  
 1792 provide that agreements negotiated between the governing board,  
 1793 agency, or authority and providers shall recognize hospitals  
 1794 that render a disproportionate share of indigent care, provide

1795 other incentives to promote the delivery of charity care to draw  
 1796 down federal funds where appropriate, and require cost  
 1797 containment, including, but not limited to, case management.  
 1798 From the funds specified in subparagraphs (d)1. and 2. for  
 1799 indigent health care services, service providers shall receive  
 1800 reimbursement at a Medicaid rate to be determined by the  
 1801 governing board, agency, or authority created pursuant to this  
 1802 paragraph for the initial emergency room visit, and a per-member  
 1803 per-month fee or capitation for those members enrolled in their  
 1804 service area, as compensation for the services rendered  
 1805 following the initial emergency visit. Except for provisions of  
 1806 emergency services, upon determination of eligibility,  
 1807 enrollment shall be deemed to have occurred at the time services  
 1808 were rendered. The provisions for specific reimbursement of  
 1809 emergency services shall be repealed on July 1, 2001, unless  
 1810 otherwise reenacted by the Legislature. The capitation amount or  
 1811 rate shall be determined prior to program implementation by an  
 1812 independent actuarial consultant. In no event shall such  
 1813 reimbursement rates exceed the Medicaid rate. The plan must also  
 1814 provide that any hospitals owned and operated by government  
 1815 entities on or after the effective date of this act must, as a  
 1816 condition of receiving funds under this subsection, afford  
 1817 public access equal to that provided under s. 286.011 as to any  
 1818 meeting of the governing board, agency, or authority the subject  
 1819 of which is budgeting resources for the retention of charity  
 1820 care, as that term is defined in the rules of the Agency for

1821 Health Care Administration. The plan shall also include  
 1822 innovative health care programs that provide cost-effective  
 1823 alternatives to traditional methods of service and delivery  
 1824 funding.

1825 3. The plan's benefits shall be made available to all  
 1826 county residents currently eligible to receive health care  
 1827 services as indigents or medically poor as defined in paragraph  
 1828 (4) (d).

1829 4. Eligible residents who participate in the health care  
 1830 plan shall receive coverage for a period of 12 months or the  
 1831 period extending from the time of enrollment to the end of the  
 1832 current fiscal year, per enrollment period, whichever is less.

1833 5. At the end of each fiscal year, the governing board,  
 1834 agency, or authority shall prepare an audit that reviews the  
 1835 budget of the plan, delivery of services, and quality of  
 1836 services, and makes recommendations to increase the plan's  
 1837 efficiency. The audit shall take into account participant  
 1838 hospital satisfaction with the plan and assess the amount of  
 1839 poststabilization patient transfers requested, and accepted or  
 1840 denied, by the county public general hospital.

1841 Section 33. Subsection (1) of section 394.657, Florida  
 1842 Statutes, is amended to read:

1843 394.657 County planning councils or committees.—

1844 (1) Each board of county commissioners shall designate the  
 1845 county public safety coordinating council established under s.  
 1846 951.26, or designate another criminal or juvenile justice mental

1847 health and substance abuse council or committee, as the planning  
 1848 council or committee. The public safety coordinating council or  
 1849 other designated criminal or juvenile justice mental health and  
 1850 substance abuse council or committee, in coordination with the  
 1851 county offices of planning and budget, shall make a formal  
 1852 recommendation to the board of county commissioners regarding  
 1853 how the Criminal Justice, Mental Health, and Substance Abuse  
 1854 Reinvestment Grant Program may best be implemented within a  
 1855 community. The board of county commissioners may assign any  
 1856 entity to prepare the application on behalf of the county  
 1857 administration for submission to the Criminal Justice, Mental  
 1858 Health, and Substance Abuse Statewide Grant Policy Review  
 1859 Committee for review. A county may join with one or more  
 1860 counties to form a consortium and use a regional public safety  
 1861 coordinating council or another county-designated regional  
 1862 criminal or juvenile justice mental health and substance abuse  
 1863 planning council or committee for the geographic area  
 1864 represented by the member counties.

1865 Section 34. Subsection (1) of section 394.658, Florida  
 1866 Statutes, is amended to read:

1867 394.658 Criminal Justice, Mental Health, and Substance  
 1868 Abuse Reinvestment Grant Program requirements.—

1869 (1) The Criminal Justice, Mental Health, and Substance  
 1870 Abuse Statewide Grant Policy Review ~~Review~~ Committee, in collaboration  
 1871 with the Department of Children and Families, the Department of  
 1872 Corrections, the Department of Juvenile Justice, the Department

1873 | of Elderly Affairs, and the Office of the State Courts  
 1874 | Administrator, shall establish criteria to be used to review  
 1875 | submitted applications and to select the county that will be  
 1876 | awarded a 1-year planning grant or a 3-year implementation or  
 1877 | expansion grant. A planning, implementation, or expansion grant  
 1878 | may not be awarded unless the application of the county meets  
 1879 | the established criteria.

1880 |       (a) The application criteria for a 1-year planning grant  
 1881 | must include a requirement that the applicant county or counties  
 1882 | have a strategic plan to initiate systemic change to identify  
 1883 | and treat individuals who have a mental illness, substance abuse  
 1884 | disorder, or co-occurring mental health and substance abuse  
 1885 | disorders who are in, or at risk of entering, the criminal or  
 1886 | juvenile justice systems. The 1-year planning grant must be used  
 1887 | to develop effective collaboration efforts among participants in  
 1888 | affected governmental agencies, including the criminal,  
 1889 | juvenile, and civil justice systems, mental health and substance  
 1890 | abuse treatment service providers, transportation programs, and  
 1891 | housing assistance programs. The collaboration efforts shall be  
 1892 | the basis for developing a problem-solving model and strategic  
 1893 | plan for treating adults and juveniles who are in, or at risk of  
 1894 | entering, the criminal or juvenile justice system and doing so  
 1895 | at the earliest point of contact, taking into consideration  
 1896 | public safety. The planning grant shall include strategies to  
 1897 | divert individuals from judicial commitment to community-based  
 1898 | service programs offered by the Department of Children and

1899 Families in accordance with ss. 916.13 and 916.17.

1900 (b) The application criteria for a 3-year implementation

1901 or expansion grant shall require information from a county that

1902 demonstrates its completion of a well-established collaboration

1903 plan that includes public-private partnership models and the

1904 application of evidence-based practices. The implementation or

1905 expansion grants may support programs and diversion initiatives

1906 that include, but need not be limited to:

1907 1. Mental health courts;

1908 2. Diversion programs;

1909 3. Alternative prosecution and sentencing programs;

1910 4. Crisis intervention teams;

1911 5. Treatment accountability services;

1912 6. Specialized training for criminal justice, juvenile

1913 justice, and treatment services professionals;

1914 7. Service delivery of collateral services such as

1915 housing, transitional housing, and supported employment; and

1916 8. Reentry services to create or expand mental health and

1917 substance abuse services and supports for affected persons.

1918 (c) Each county application must include the following

1919 information:

1920 1. An analysis of the current population of the jail and

1921 juvenile detention center in the county, which includes:

1922 a. The screening and assessment process that the county

1923 uses to identify an adult or juvenile who has a mental illness,

1924 substance abuse disorder, or co-occurring mental health and

1925 substance abuse disorders;

1926       b. The percentage of each category of persons admitted to  
 1927 the jail and juvenile detention center that represents people  
 1928 who have a mental illness, substance abuse disorder, or co-  
 1929 occurring mental health and substance abuse disorders; and

1930       c. An analysis of observed contributing factors that  
 1931 affect population trends in the county jail and juvenile  
 1932 detention center.

1933       2. A description of the strategies the county intends to  
 1934 use to serve one or more clearly defined subsets of the  
 1935 population of the jail and juvenile detention center who have a  
 1936 mental illness or to serve those at risk of arrest and  
 1937 incarceration. The proposed strategies may include identifying  
 1938 the population designated to receive the new interventions, a  
 1939 description of the services and supervision methods to be  
 1940 applied to that population, and the goals and measurable  
 1941 objectives of the new interventions. The interventions a county  
 1942 may use with the target population may include, but are not  
 1943 limited to:

1944       a. Specialized responses by law enforcement agencies;

1945       b. Centralized receiving facilities for individuals  
 1946 evidencing behavioral difficulties;

1947       c. Postbooking alternatives to incarceration;

1948       d. New court programs, including pretrial services and  
 1949 specialized dockets;

1950       e. Specialized diversion programs;

1951 f. Intensified transition services that are directed to  
 1952 the designated populations while they are in jail or juvenile  
 1953 detention to facilitate their transition to the community;

1954 g. Specialized probation processes;

1955 h. Day-reporting centers;

1956 i. Linkages to community-based, evidence-based treatment  
 1957 programs for adults and juveniles who have mental illness or  
 1958 substance abuse disorders; and

1959 j. Community services and programs designed to prevent  
 1960 high-risk populations from becoming involved in the criminal or  
 1961 juvenile justice system.

1962 3. The projected effect the proposed initiatives will have  
 1963 on the population and the budget of the jail and juvenile  
 1964 detention center. The information must include:

1965 a. The county's estimate of how the initiative will reduce  
 1966 the expenditures associated with the incarceration of adults and  
 1967 the detention of juveniles who have a mental illness;

1968 b. The methodology that the county intends to use to  
 1969 measure the defined outcomes and the corresponding savings or  
 1970 averted costs;

1971 c. The county's estimate of how the cost savings or  
 1972 averted costs will sustain or expand the mental health and  
 1973 substance abuse treatment services and supports needed in the  
 1974 community; and

1975 d. How the county's proposed initiative will reduce the  
 1976 number of individuals judicially committed to a state mental

1977 health treatment facility.

1978 4. The proposed strategies that the county intends to use  
 1979 to preserve and enhance its community mental health and  
 1980 substance abuse system, which serves as the local behavioral  
 1981 health safety net for low-income and uninsured individuals.

1982 5. The proposed strategies that the county intends to use  
 1983 to continue the implemented or expanded programs and initiatives  
 1984 that have resulted from the grant funding.

1985 Section 35. Subsection (6) of section 394.9085, Florida  
 1986 Statutes, is amended to read:

1987 394.9085 Behavioral provider liability.-

1988 (6) For purposes of this section, the terms  
 1989 "detoxification services," "addictions receiving facility," and  
 1990 "receiving facility" have the same meanings as those provided in  
 1991 ss. 397.311(23)(a)4., 397.311(23)(a)1. ~~397.311(22)(a)4.~~,  
 1992 ~~397.311(22)(a)1.~~, and 394.455(26), respectively.

1993 Section 36. Subsection (8) of section 397.405, Florida  
 1994 Statutes, is amended to read:

1995 397.405 Exemptions from licensure.-The following are  
 1996 exempt from the licensing provisions of this chapter:

1997 (8) A legally cognizable church or nonprofit religious  
 1998 organization or denomination providing substance abuse services,  
 1999 including prevention services, which are solely religious,  
 2000 spiritual, or ecclesiastical in nature. A church or nonprofit  
 2001 religious organization or denomination providing any of the  
 2002 licensed service components itemized under s. 397.311(23)

2003 | ~~397.311(22)~~ is not exempt from substance abuse licensure but  
 2004 | retains its exemption with respect to all services which are  
 2005 | solely religious, spiritual, or ecclesiastical in nature.  
 2006 |  
 2007 | The exemptions from licensure in this section do not apply to  
 2008 | any service provider that receives an appropriation, grant, or  
 2009 | contract from the state to operate as a service provider as  
 2010 | defined in this chapter or to any substance abuse program  
 2011 | regulated pursuant to s. 397.406. Furthermore, this chapter may  
 2012 | not be construed to limit the practice of a physician or  
 2013 | physician assistant licensed under chapter 458 or chapter 459, a  
 2014 | psychologist licensed under chapter 490, a psychotherapist  
 2015 | licensed under chapter 491, or an advanced registered nurse  
 2016 | practitioner licensed under part I of chapter 464, who provides  
 2017 | substance abuse treatment, so long as the physician, physician  
 2018 | assistant, psychologist, psychotherapist, or advanced registered  
 2019 | nurse practitioner does not represent to the public that he or  
 2020 | she is a licensed service provider and does not provide services  
 2021 | to individuals pursuant to part V of this chapter. Failure to  
 2022 | comply with any requirement necessary to maintain an exempt  
 2023 | status under this section is a misdemeanor of the first degree,  
 2024 | punishable as provided in s. 775.082 or s. 775.083.

2025 | Section 37. Subsections (1) and (5) of section 397.407,  
 2026 | Florida Statutes, are amended to read:

2027 | 397.407 Licensure process; fees.—

2028 | (1) The department shall establish the licensure process

2029 | to include fees and categories of licenses and must prescribe a  
 2030 | fee range that is based, at least in part, on the number and  
 2031 | complexity of programs listed in s. 397.311(23) ~~397.311(22)~~  
 2032 | which are operated by a licensee. The fees from the licensure of  
 2033 | service components are sufficient to cover at least 50 percent  
 2034 | of the costs of regulating the service components. The  
 2035 | department shall specify a fee range for public and privately  
 2036 | funded licensed service providers. Fees for privately funded  
 2037 | licensed service providers must exceed the fees for publicly  
 2038 | funded licensed service providers.

2039 |       (5) The department may issue probationary, regular, and  
 2040 | interim licenses. The department shall issue one license for  
 2041 | each service component that is operated by a service provider  
 2042 | and defined pursuant to s. 397.311(23) ~~397.311(22)~~. The license  
 2043 | is valid only for the specific service components listed for  
 2044 | each specific location identified on the license. The licensed  
 2045 | service provider shall apply for a new license at least 60 days  
 2046 | before the addition of any service components or 30 days before  
 2047 | the relocation of any of its service sites. Provision of service  
 2048 | components or delivery of services at a location not identified  
 2049 | on the license may be considered an unlicensed operation that  
 2050 | authorizes the department to seek an injunction against  
 2051 | operation as provided in s. 397.401, in addition to other  
 2052 | sanctions authorized by s. 397.415. Probationary and regular  
 2053 | licenses may be issued only after all required information has  
 2054 | been submitted. A license may not be transferred. As used in

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2055 | this subsection, the term "transfer" includes, but is not  
 2056 | limited to, the transfer of a majority of the ownership interest  
 2057 | in the licensed entity or transfer of responsibilities under the  
 2058 | license to another entity by contractual arrangement.

2059 |       Section 38. Section 397.416, Florida Statutes, is amended  
 2060 | to read:

2061 |       397.416 Substance abuse treatment services; qualified  
 2062 | professional.—Notwithstanding any other provision of law, a  
 2063 | person who was certified through a certification process  
 2064 | recognized by the former Department of Health and Rehabilitative  
 2065 | Services before January 1, 1995, may perform the duties of a  
 2066 | qualified professional with respect to substance abuse treatment  
 2067 | services as defined in this chapter, and need not meet the  
 2068 | certification requirements contained in s. 397.311(31)  
 2069 | ~~397.311(30)~~.

2070 |       Section 39. Paragraph (e) of subsection (3) of section  
 2071 | 409.966, Florida Statutes, is amended to read:

2072 |       409.966 Eligible plans; selection.—

2073 |       (3) QUALITY SELECTION CRITERIA.—

2074 |       (e) To ensure managed care plan participation in Regions 1  
 2075 | and 2, the agency shall award an additional contract to each  
 2076 | plan with a contract award in Region 1 or Region 2. Such  
 2077 | contract shall be in any other region in which the plan  
 2078 | submitted a responsive bid and negotiates a rate acceptable to  
 2079 | the agency. If a plan that is awarded an additional contract  
 2080 | pursuant to this paragraph is subject to penalties pursuant to

2081 s. 409.967(2)(i) ~~409.967(2)(h)~~ for activities in Region 1 or  
 2082 Region 2, the additional contract is automatically terminated  
 2083 180 days after the imposition of the penalties. The plan must  
 2084 reimburse the agency for the cost of enrollment changes and  
 2085 other transition activities.

2086 Section 40. Paragraphs (d) and (g) of subsection (1) of  
 2087 section 440.102, Florida Statutes, are amended to read:

2088 440.102 Drug-free workplace program requirements.—The  
 2089 following provisions apply to a drug-free workplace program  
 2090 implemented pursuant to law or to rules adopted by the Agency  
 2091 for Health Care Administration:

2092 (1) DEFINITIONS.—Except where the context otherwise  
 2093 requires, as used in this act:

2094 (d) "Drug rehabilitation program" means a service  
 2095 provider, established pursuant to s. 397.311(40) ~~397.311(39)~~,  
 2096 that provides confidential, timely, and expert identification,  
 2097 assessment, and resolution of employee drug abuse.

2098 (g) "Employee assistance program" means an established  
 2099 program capable of providing expert assessment of employee  
 2100 personal concerns; confidential and timely identification  
 2101 services with regard to employee drug abuse; referrals of  
 2102 employees for appropriate diagnosis, treatment, and assistance;  
 2103 and followup services for employees who participate in the  
 2104 program or require monitoring after returning to work. If, in  
 2105 addition to the above activities, an employee assistance program  
 2106 provides diagnostic and treatment services, these services shall

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2107 | in all cases be provided by service providers pursuant to s.  
2108 | 397.311(40) ~~397.311(39)~~.

2109 |       Section 41. Except as otherwise expressly provided in this  
2110 | act and except for this section, which shall take effect upon  
2111 | this act becoming a law, this act shall take effect July 1,  
2112 | 2016.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 7097 (2016)

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED                                   \_\_\_ (Y/N)  
ADOPTED AS AMENDED                   \_\_\_ (Y/N)  
ADOPTED W/O OBJECTION               \_\_\_ (Y/N)  
FAILED TO ADOPT                       \_\_\_ (Y/N)  
WITHDRAWN                               \_\_\_ (Y/N)  
OTHER                                     \_\_\_\_\_

1 Committee/Subcommittee hearing bill: Health Care Appropriations  
2 Subcommittee

3 Representative Harrell offered the following:

4  
5           **Amendment (with title amendment)**

6           Between lines 2108 and 2109, insert:

7           Section 40. For Fiscal Year 2016-17, the nonrecurring sum  
8 of \$400,000 from the Operations and Maintenance Trust Fund is  
9 provided to the Department of Children & Families for the  
10 purpose of modifying the existing Crisis Stabilization Unit  
11 database to collect and analyze data and information pursuant to  
12 section 10 of this act.

13  
14 -----  
15                                   **T I T L E   A M E N D M E N T**

16           Remove line 143 and insert:

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 7097 (2016)

Amendment No. 1

17 | made by the act; providing an appropriation; providing effective  
18 | dates.

19





