HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: CS/HB 1501 Health Care Innovation
SPONSOR(S): Health Care Appropriations Subcommittee, Gonzalez Pittman and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 7018

FINAL HOUSE FLOOR ACTION: 117**Y's** 1**N's** **GOVERNOR'S ACTION:** Approved

SUMMARY ANALYSIS

CS/HB 1501 passed the House on February 22, 2024, as SB 7018.

The bill creates the Health Care Innovation Council, a 15-member council within the Department of Health (DOH) to facilitate public meetings across the state to lead discussions with innovators, developers, and implementers of technologies, workforce pathways, service delivery models, or other solutions. The bill requires the council to create best practice recommendations and focus areas for the advancement of the delivery of health care in Florida. The Council must emphasize:

- Increasing efficiency in the delivery of health care;
- Reducing strain on the health care workforce;
- Increasing public access to health care;
- Improving patient outcomes;
- Reducing unnecessary emergency department visits; and
- Reducing costs for patients and the state without reducing the quality of patient care.

The bill creates a revolving loan program within the DOH to provide low-interest loans to applicants to implement one or more innovative technologies, workforce pathways, or service delivery models in order to:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or
- A combination thereof to improve the quality and delivery of health care in measurable and sustainable ways that will lower costs and allow that value to be passed onto health care consumer.

The council will review loan applications and submit to the DOH a prioritized list of proposals recommended for funding. Loan recipients enter into agreements with the DOH for loans of up to 10-year terms for up to 50 percent of the proposal costs, or up to 80 percent of the costs for an applicant that is located in a rural or medically underserved area and is either a rural hospital or a nonprofit entity that accepts Medicaid patients.

The bill requires both the council and the DOH to publicly report certain information related to the activities required under the bill and requires the Office of Economic and Demographic Research (EDR) and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to evaluate specified aspects of the revolving loan program every five years.

The bill appropriates $51,250,000 in recurring and nonrecurring funds to DOH to implement its provisions, and has no fiscal impact on local government.

The bill was approved by the Governor on March 21, 2024, ch. 2024-16, L.O.F., and became effective on that date.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Background

Challenges of the Health Care System

There are numerous challenges facing the health care system in the United States, including provider shortages, lack of access for certain populations, affordability, and ongoing challenges with health care outcomes for certain populations. Compared with other wealthy nations, Americans have poorer health, lower life expectancy, and less access to health care.[1]

Health Care Professional Shortages

The United States has a current health care professional shortage. The U. S. Department of Health and Human Services designates an area, population group, or facility as a Health Professional Shortage Area (HPSA) if it is experiencing a shortage of professionals.[2] The three types of HPSAs are:

- Geographic HPSAs, which have a shortage of services for the entire population within an established geographic area;
- Populations HPSAs, which have a shortage of services for a particular population subset within an established geographic area, such as low income, migrant farmworker, or Medicaid eligible; and
- Facility HPSAs, which indicate shortages in facilities such as correctional facilities, state or county hospitals with a shortage of psychiatrists, and other public or non-private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers.

As of December 3, 2023, there are 8,544 Primary Care HPSAs, 7,651 Dental HPSAs, and 6,822 Mental Health HPSAs nationwide. To eliminate the shortages, an additional 17,637 primary care practitioners, 13,354 dentists, and 8,504 psychiatrists are needed, respectively.[3]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population.[4] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.[5] By 2030, all baby-boomers will be over the age of 65, and by 2034, it is projected that the number of individuals over the age of 65 will surpass the number of children under the age of 18 for the first time in U.S. history.[6] 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.

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[1] Centers for Disease Control and Prevention, *U.S. Health Disadvantage: Causes and Potential Solutions*, (last reviewed Jan. 7, 2022), available at https://www.cdc.gov/policy/chep/health/index.html (last visited Mar. 6, 2024).
[2] U.S. Department of Health and Human Services, Guidance Portal, *Health Professional Shortage Areas (HPSAs and Medically Underserved Populations (MUA/P) Shortage Designation Types* (Aug. 1, 2019), available at https://www.hhs.gov/guidance/document/hpsa-and-muap-shortage-designation-types (last visited Mar. 6, 2024).
[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas*, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited Dec. 19, 2023).
[4] The U.S. population is projected to increase from almost 336 million in 2023 to nearly 370 million in 2080, before decreasing to 366 million in 2100. *See* U.S. Census Bureau, *U.S. and World Population Clock*, available at https://www.census.gov/popclock/, and U.S. Census Bureau, U.S. Population Projected to Begin Declining in Second Half of Century (last revised Nov. 16, 2023), available at https://www.census.gov/newsroom/press-releases/2023/population-projections.html (both sites last visited Mar. 6, 2024).
[5] *Id*. at 33.
[6] J. Vespa, L. Medina, and D. Armstrong, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060*, United States Census Bureau (Mar. 208, rev. Feb, 2020), available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited Mar. 6, 2024).

Health care workers may experience an extreme amount of stress due to the demanding work conditions, including taxing work, exposure to infectious diseases, long hours, and challenging interactions with coworkers, patients, and their families.[7] Prior to the COVID-19 pandemic, the National Academy of Medicine found that burnout had reached a crisis level, with 35-45 percent of nurses and physicians and 45-60 percent of medical students and residents reporting symptoms of burnout.[8] During the pandemic, the high levels of stress and the increased demands for care led to record numbers of health care workers quitting or planning to quit.[9] In 2022, nearly one half of health care workers reported burnout.[10]

Florida is not immune to the national problem and is also experiencing a health care practitioner shortage. This is evidenced by the fact that as of December 31, 2023, Florida has 320 primary care HPSAs, 295 dental HPSAs, and 237 mental health HPSAs. It would take an additional 1,843 primary care physicians, 1,536 dentists, and 587 psychiatrists to eliminate these shortage areas.[11]

According to data from the DOH, by 2035, Florida will need 17,924 physicians, 50,700 registered nurses, and 4,000 licensed practical nurses to meet the demand in Florida.[12] In the next five years almost 10 percent of Florida physicians are planning to retire, and in nine counties, at least 25 percent of physicians are planning to retire.[13] Nurses make up the largest segment of Florida's health care workforce. Approximately 20 percent of the nursing workforce is over the age of 60 and may leave the workforce in the next five to ten years.[14]

Access to Health Care

Access to health care means the timely use of personal health services to achieve the best possible health outcomes.[15] There are several barriers that limit an individual's access to health care services. Some lack access because they reside in a medically underserved area or are members of a medically underserved population, which means that they lack access to primary health care services.[16] Florida has approximately 130 federally designated medically underserved areas or populations.[17]

Other factors that play a role in access to health care include health care affordability and the lack of health insurance coverage.[18] Studies show that having health insurance is associated with improved access to health services and better health monitoring. Additionally, nonfinancial barriers significantly

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[7] J. Nigam, et. al., *Vital Signs: Health Worker-Perceived Working Conditions and Symptoms of Poor Mental Health – Quality of Worklife Survey, United States, 2018-2022*, MORBIDITY AND MORTALITY WEEKLY REPORT (Oct. 24, 2023), available at https://www.cdc.gov/mmwr/volumes/72/wr/pdfs/mm7244e1-H.pdf (last visited Mar. 6, 2024).
[8] Office of the Surgeon General, *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce* (2022), available at https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf (last visited Mar. 6, 2024). "Burnout" is an occupational syndrome characterized by a high degree of emotional exhaustion and depersonalization and a low sense of personal accomplishment at work.
[9] *Id*. at 14.
[10] *Supra*, FN 7.
[11] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, First Quarter of Fiscal Year 2024* (Dec. 31, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited Mar. 6, 2024). To generate the report, select "Designated HPSA Quarterly Summary."
[12] Presentation before the Florida Senate Committee on Health Policy by Emma Spencer, Department of Health, *Florida's Physician and Nursing Workforce* (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited Mar. 6, 2024).
[13] *Id*. Those counties are Glades, Gulf, Hamilton, Madison, Union, Calhoun, Hendry, Levy, and Liberty.
[14] *Id*.
[15] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Healthy People 2030, Access to Health Services*, available at https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services (last visited Mar. 6, 2024). (Hereinafter "Healthy People 2030").
[16] Health and Resources Services Administration, *What is Shortage Designation?*, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation (last visited Mar. 6, 2024).
[17] *See*, Heath Resources and Services Administration, *MUA Find*, available at https://data.hrsa.gov/tools/shortage-area/mua-find (last visited Mar. 6, 2024). To generate a list of medically underserved areas and populations, select Florida as the search criteria.
[18] Centers for Disease Control and Prevention, Division of Heart Disease and Stroke Prevention, *Health Care Access*, (last reviewed Sept. 1, 2023) available at https://www.cdc.gov/dhdsp/health_equity/health-care-access.htm (last visited Mar. 6, 2024).

impact a patient's ability to access care. Among the most prevalent nonfinancial barriers are the ability to get an appointment and inconvenient or unreliable transportation.[19]

Health Care Outcomes

Although the United States spends more on health care per capita than other wealthy nations, it has some of the worst health care outcomes, according to an issue brief published by The Commonwealth Fund. Compared to other wealthy nations, the U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates, according to the issue brief.[20]

Sixty percent of adults in the U.S. have a chronic health condition, and 40 percent have two or more.[21] A chronic condition is a physical or mental health condition that lasts more than one year and causes functional restrictions or requires ongoing monitoring or treatment.[22] Chronic health conditions are the leading drivers of the nation's $4.1 trillion in health care costs, accounting for nearly 75 percent of aggregate health spending.[23] More than two thirds of all deaths are caused by one or more of the five most prevalent chronic health conditions: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. Unfortunately, these outcomes are because of the nation's inability to effectively manage chronic conditions, which could be achieved by reducing unhealthy behaviors.[24]

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[25] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019. The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births. Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.[26] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[27]

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.[28] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida.

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[19] Healthy People 2030, *supra*, note 156.
[20] M. Gunja, Evan Gumas, and R. Williams, The Commonwealth Fund, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Jan. 31, 2023), available at https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 (last visited Mar. 6, 2024). Other wealthy nations included in the study are Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland, and the United Kingdom.
[21] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *About Chronic Diseases*, (last reviewed Jul. 21, 2022), available at https://www.cdc.gov/chronicdisease/about/index.htm (last visited Mar. 6, 2024).
[22] W. Raghupathi and V. Rahupathi, *An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health*, INTERNATIONAL JOURNAL ON ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH, 15(3):431 (Mar. 2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5876976/ (last visited Mar. 6, 2024).
[23] *Id*., and CDC, *supra*, note 22.
[24] *Id*.
[25] U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health* (Dec. 2020), available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (last visited Mar. 6, 2024).
[26] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021* (Mar. 2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf (last visited Mar. 6, 2024).
[27] United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic* (Oct. 2022), available at https://www.gao.gov/assets/gao-23-105871.pdf (last visited Mar. 6, 2024).
[28] Presentation before the Florida Senate Committee on Health Policy by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Secretary for Health, Department of Health, *Telehealth Minority Care Pilot Program* (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited Mar. 6, 2024).

Infant mortality is the death of an infant before his or her first birthday. The leading causes of infant death are:

- Birth defects;
- Preterm birth and low birth weight;
- Sudden infant death syndrome;
- Injuries (i.e. suffocation); and
- Maternal pregnancy complications.[29]

The 2022 infant mortality rate in the U.S. was projected to be 5.6 deaths per 1,000 live births, which was three percent higher than the infant mortality rate in 2021 (5.44).[30] Except for the infants of Asian mothers, mortality rates have increased for all races: American Indian and Alaska native infants from 7.46 to 9.06; white infants from 4.36 to 4.52, black infants from 10.55 to 10.86, native Hawaiian and other Pacific Islander infants from 7.76 to 8.50, and Hispanic infants from 4.79 to 4.88 per 1,000 live births.[31] From 2021 to 2022, Florida's infant mortality rate increased from 5.90 to 5.98 per 1,000 live births. In 2020, the infant mortality rate was more than double the rate for white and Hispanic infants in Florida.[32]

Advancements in Health Care

In the last century, there have been tremendous advances in health care. From the development of vaccines to suppress the spread of diseases that were once considered debilitating or fatal, such as polio,[33] to the first successful organ transplant in 1954, and the development of numerous technologies and medical devices that provide new options for care and treatment.[34] During the last century, there have been numerous clinical innovations, such as the development of medications to make once fatal diseases an almost curable disease, such as AIDS, and the use of genetics to allow for individualized cancer treatments.[35] Despite the many advances in health care technology, the health care delivery system has been slower to change.

Historically, health care primarily involved the prevention and treatment of disease and episodes of acute care; however, health care has evolved to be increasingly occupied with the management of chronic health conditions. Chronic illness is the leading cause of illness, disability, and death in the United States, and accounts for 78 percent of health care expenditures.[36]

Within recent years, and especially during the COVID-19 pandemic, there has been an increase in interest in alternative delivery systems. For example, prior to the pandemic, the use of telehealth was growing; however, during the pandemic, the use of the technology rose by more than 760 percent.[37] As a subset of telehealth, many health care practitioners also adopted the use of remote patient monitoring to manage acute and chronic conditions. Remote patient monitoring may be used to assess high blood pressure, diabetes, weight loss or gain, heart conditions, chronic obstructive pulmonary disease, sleep

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[29] Centers for Disease Control and Prevention, *Infant Mortality*, (last reviewed Sept. 13, 2023) available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last visited Mar. 6, 2024).
[30] D. Ely and K. Driscoll, Centers for Disease Control and Prevention, National Center for Health Statistics, *Infant Mortality in the United States: Provisional Data from the 2022 Period Linked Birth/Infant Death File*, Vital Statistics Rapid Release, Report No. 33 (Nov. 2023), available at https://www.cdc.gov/nchs/data/vsrr/vsrr033.pdf (last visited Mar. 6, 2024).
[31] *Id*.
[32] Department of Health, *Infant Mortality in Florida*, available at https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/infant-mortality-FL-.pdf (last visited Mar. 6, 2024).
[33] The vaccine for polio was developed in the early 1950s. *See* World Health Organization, *History of the Polio Vaccine*, available at https://www.who.int/news-room/spotlight/history-of-vaccination/history-of-polio-vaccination (last visited Mar. 6, 2024).
[34] Institute of Medicine, *Evidence-Based Medicine and the Changing Nature of Healthcare: 2007 IOM Annual Meeting Summary*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK52825/ (last visited Mar. 6, 2024).
[35] Gary Ahlquist, et. al, Strategy&, *The (R)evolution of Healthcare*, available at https://www.strategyand.pwc.com/gx/en/industries/health/the-revolution-of-healthcare.pdf (last visited Mar. 6, 2024).
[36] Institute of Medicine, *supra*, note 37.
[37] Julia Shaver, M.D., *The State of Telehealth Before and After the COVID-19 Pandemic*, PRIMARY CARE 49(4): 517-530 (Dec. 2022), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/ (last visited Mar. 6, 2024).

apnea, or asthma. Using remote patient monitoring may reduce hospitalizations, reduce the length of hospital stays, reduce emergency department visits, and provide better health outcomes, among other things.[38]

Another technological advance that has been widely adopted is the use of an electronic health record (EHR).[39] EHRs offer a number of benefits, such as automating certain tasks, reducing the incidence of medical errors, and making health information more readily available, which reduces duplication of tests, delays in treatment, and enables patients to make better informed decisions.[40]

In addition to advancements in health care technologies and delivery systems, there has also been an evolution in payment models. In recent years, there has been a move to value-based care models. Under these models, providers, such as hospitals and physicians, are paid based on patient outcomes. Providers are rewarded for achievements such as helping the health of their patients to improve and reducing the effects of chronic illness.[41]

Health Care Innovation Initiatives

In recent years, both the state and federal governments have launched or funded programs to examine innovations in health care. Many of the programs were predicated on grants from the Center for Medicare and Medicaid Innovation (CMS Innovation Center).[42]

In 2010, Congress established the CMS Innovation Center to identify ways to improve health care quality and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[43] The CMS Innovation Center's demonstration projects and models measure the effect of potential program changes, while evaluation projects validate research and help to monitor the effectiveness of Medicare, Medicaid, and CHIP.[44]

Effect of Proposed Changes

The bill creates a revolving loan program within the Department of Health (DOH) to provide low-interest loans to applicants to implement one or more health care innovative technologies, workforce pathways, or service delivery models in order to improve health care quality and delivery in ways that will reduce consumer costs. The bill establishes the 15-member Health Care Innovation Council (Council) within DOH to review loan applications and submit to DOH a prioritized list of proposals recommended for funding. In addition, the bill requires the Council to facilitate public meetings across the state to lead discussions with innovators, developers, and implementers of technologies, workforce pathways, service delivery models, or other solutions.

Health Care Innovation Council

[38] Telehealth.HHS.gov, *Telehealth and Remote Patient Monitoring*, (last updated May 11, 2023) available at https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/telehealth-and-remote-patient-monitoring (last visited Mar. 6, 2024).
[39] An electronic health record is a digital version of a patient's paper chart. *See* The Office of the National Coordinator for Health Information Technology, HealthIT.gov, *Frequently Asked Questions*, available at https://www.healthit.gov/faq/what-electronic-health-record-ehr (last visited Mar. 6, 2024).
[40] Centers for Medicare and Medicaid Services, *Electronic Health Records*, (last modified Sept. 6, 2023), available at https://www.cms.gov/priorities/key-initiatives/e-health/records (last visited Mar. 6, 2024).
[41] NEJM Catalyst, *What is Value-Based Healthcare?* (Jan. 1, 2017), available at https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558 (last visited Mar. 6, 2024).
[42] For example, see the Delaware Center for Health Innovation, available at https://www.dehealthinnovation.org/; Rhode Island Health Care Innovation Initiative, available at https://eohhs.ri.gov/initiatives/healthcare-innovation; Oklahoma Center for Health Innovation and Effectiveness, available at https://oklahoma.gov/health/about-us/center-for-health-innovation-and-effectiveness.html (all sites last visited Mar. 6, 2024).
[43] Centers for Medicare and Medicaid Services, *About the CMS Innovation Center*, (last modified Jan. 5, 2024), available at https://www.cms.gov/priorities/innovation/About (last visited Mar. 6, 2024).
[44] Centers for Medicare and Medicaid Services, *CMS Innovation Center Programs*, available at https://data.cms.gov/cms-innovation-center-programs (last visited Mar. 6, 2024).

Administration

The bill creates the Council within DOH for administrative purposes, and requires DO to make necessary staff support and materials available to assist it. DOH must also must maintain a weblink on its homepage that directs the public to the Council's website. The bill makes DOH responsible for posting information germane to the Council, such as performance outcomes and annual reports.

Membership

The bill installs certain executive branch officials on the Council to serve as ex officio, nonvoting members: the Lieutenant Governor, the AHCA Secretary, the DCF Secretary, the APD Director, the State Surgeon General, and the DEA Secretary. The bill requires the Lieutenant Governor to chair the Council.

The bill installs the chairperson of Council of Florida Medical School Deans serves as a voting member. The bill makes the remainder of the seats on the Council with voting powers subject to legislative appointment and gubernatorial appointment.

Concerning legislative appointments, the bill requires the President of the Senate and the Speaker of the House of Representatives to each make one appointment to the Council. The bill narrowly tailors the pool of prospective legislative appointments by advising these legislative officers to prioritize private sector leaders who meet least one of four core, experience-based criteria. Accordingly, the bill prioritizes:

- Health care professionals with senior-level experience in diminishing health care delivery system efficiencies;
- Business professionals with senior-level experience in cybersecurity or software engineering in the health care sector;
- Persons whose emerging technology expertise is transferrable to health care delivery subject matter; or
- Persons with experience in finance, investment, or in the management and operation of early stage companies.

As to gubernatorial appointments, the bill requires the Governor to appoint six members to the Council.

- A licensed allopathic or osteopathic physician;
- A licensed nurse;
- An employee of a licensed hospital with executive-level experience;
- A representative of the long-term care facility industry.
- An employee of a health insurer or health maintenance organization, with executive-level experience; and
- A Florida resident with the capacity to represent the interest of health care patients.

The bill requires both legislative and gubernatorial appointments to be made by July 1, 2024. Appointees serve two-year terms and may be reappointed for no more than four consecutive terms.[45] Vacancies are filled in the same manner as the appointment, and members whose terms are expired may continue to serve for up to six months until replaced or reappointed. Members serve without compensation but are entitled to per diem and travel expenses. A member may be removed for cause by the appointing entity. Members who are not already required to file a financial disclosure statement must file a disclosure of financial interests.

[45] The bill provides that the legislative appointees, the physician, and the nurse all serve initial terms of three years in order to create staggered terms.

Meetings

The bill requires the council to hold its first meeting by September 1, 2024. The Council must subsequently meet at least quarterly at the call of the chair. The bill requires a majority of Council meetings for each year to occur in geographically dispersed locations. The purpose of Council meetings is for members of the public to showcase innovative solutions in health care technologies, workforce pathways, or service delivery models meant to improve health care quality and delivery in ways to reduce consumer costs.

A majority of the members represents a quorum, which is required for meetings and can be established by conducting the meeting using teleconference or other electronic means. An affirmative vote by a majority of members present at the meeting is necessary for any official action.

The bill prohibits any council member from voting or considering any matter which would directly benefit the member or which would benefit a relative or person or entity with which the member has a business relationship.[46]

The bill requires all state agencies and statutorily created state entities to assist and cooperate with the council as requested. The bill requires DOH to administratively support the council, including providing reasonable support staff and maintaining a website for the council.

The bill subjects the Council to the public records requirements under ch. 119, F.S., and the public meetings requirements of ch. 286, F.S.

Duties of the Council

The bill charges the Council to exercise seven responsibilities to fulfill the purposes of the bill.

First, by February 1, 2025, the bill requires the Council to adopt a document that sets forth a mission statement, goals, and objectives for it to function and meet the purposes of the law. The Council must update this document as necessary.

Second, the Council must facilitate public meetings at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions. The work:

- Must cover concepts that address challenges to the health care system as they develop in real time and concepts that advance the delivery of health care in this state through technology and innovation.
- Must consider how the concepts:
    - Increase efficiency in the health care system in this state;
    - Reduce strain on the state's health care workforce;
    - Improve patient outcomes;
    - Expand public access to health care services in this state; or
    - Reduce costs for patients and the state without reducing the quality of patient care.
- May consider broad community or statewide issues or needs to be addressed.
- May include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payers, patients, and the state.
- May include coordination with the Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other business

[46] "Relative" is defined as a father, mother, son, daughter, husband, wife, brother, sister, grandparent, father-in-law, mother-in-law, son-in-law, or daughter-in-law. "Business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent company, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association.

incubators, development organizations, or institutions of higher education to include emerging and early stage concepts in the discussions.
- May bring information technology technical experts to lead discussions on recommended structures and integrations of information technology products, services, and solutions.

Third, the bill requires the Council to annually distinguish the most impactful concepts, projects, and initiatives. The recognition must be for those that the Council finds to have a positive impact in Florida, have huge potential to scale that impact throughout this state through growth or replication, or are cutting-edge advancements, programs, or other innovations that have the capability to accelerate transformation of health care in Florida. The bill authorizes the Council to develop a logo for awardees to display.

Fourth, the bill requires the Council to use input received to develop and update best practice recommendations and a list of focus areas in which to advance the delivery of health care through innovative technologies, workforce pathways, or service delivery models.

The best practice recommendations[47] must:

- Be made for health care service delivery models and focus on how to explore implementation of innovations and how to implement new technologies and strategies, at a minimum;
- Be distinguished by practice setting and with an emphasis on increasing efficiency in the delivery of health care, reducing strain on the health care workforce, increasing public access to health care, improving patient outcomes, reducing unnecessary emergency department visits, and reducing costs for patients and the state without reducing the quality of patient care;
- Specifically, for information technology, also recommend actions to guide the selection of technologies and innovations, which may include considerations for system-to-system integration, consistent user experiences for health care workers and patients, and patient education and practitioner training; and
- Be updated as necessary.

The list of focus areas must, at a minimum, consider:

- The health care workforce (such as approaches to cultivate interest in the workforce, efforts to improve the workforce, education pathways, and use of technology to reduce workforce burdens);
- The provision of patient care in the most appropriate setting and reduction of unnecessary emergency department visits (such as use of advanced technologies to improve patient outcomes, use of early detection devices, at-home patient monitoring, advanced at-home care, and advanced adaptive equipment);
- The delivery of primary care through methods, practices, or procedures that increase efficiencies; and
- The technical aspects of the provision of health care (such as interoperability of electronic health records systems and the protection of health care data and systems).

Fifth, the Council must identify and recommend changes to law or rule that are necessary to advance, transform, or innovate health care or to implement its duties or recommendations.

Sixth, the Council must submit an annual report each December 1 on its activities, including:

- An update on the status of the delivery of health care in Florida;
- Information on implementation of best practices by Florida health care industry stakeholders; and

[47] The bill requires DOH to incorporate the Council's best practice recommendations into its duties , including updating administrative rules or procedures, as appropriate.

- Highlights of exploration, development, or implementation of innovative technologies, workforce pathways, service delivery models, or other solutions by Florida health care industry stakeholders.

Finally, the Council must assist DOH in implementing the Innovation Loan Program created by the bill.

Innovation Loan Program

The bill creates a revolving loan program within the DOH to provide funding for applicants seeking to implement innovative solutions. A revolving loan fund is a gap financing instrument that leverages a self-replenishing pool of money to repurpose interest and principal payments on old loans towards the award of new loans.[48] To jumpstart the revolving loan fund with initial cash flow, the fund will receive an appropriation from a combination of local, state, and federal governments and perhaps sources of private capital (usually in the form of a grant) from financial institutions and philanthropic organizations.[49]

[48] Council of Development Finance Agencies, *Revolving Loan Funds & Development Finance*, https://www.cdfa.net/cdfa/cdfaweb.nsf/pages/revolving-loan-funds.html (last visited Mar. 25, 2024).
[49] *Id*.

Application Process

The bill requires DOH to establish an application process to receive revolving loan applications for review by the Council, loan eligibility criteria to guide the Council's review and recommendation of applications, and rules meant to vet applicants, project impact, and further the purposes of the revolving loan program.

Eligibility

The bill authorizes 20 different types of health care entities licensed, registered, or certified by the Agency for Health Care Administration (AHCA) to apply for a revolving loan. While Section 408.802, F.S., lists 25 entities under the licensing and regulatory jurisdiction of AHCA,[50] the bill specifically excludes five entities from loan eligibility.[51] In addition, the bill authorizes educational and clinical training providers who partner with one of the eligible 20 entities to apply for a revolving loan. The bill advises DOH and the Council to prioritize applicants located in DOH-designated rural or medically underserved areas that are rural hospital applicants or nonprofit applicants that accept Medicaid patients.

The bill requires DOH to establish investment decision-making guidelines to help DOH and the Council determine which proposals are likely to provide the greatest return to the state. The bill requires these guidelines to consider the degree to which each proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

In addition to these loan eligibility criteria, the bill authorizes DOH to incorporate any of the Council's recommendations for eligibility criteria.

The bill disqualifies otherwise eligible applicants who have a conflict-of-interest relationship with a Council member unless that council member recuses himself/herself from consideration of the application. If a council member voted to recommend an application for funding with which the member has a conflict of interest, the applicant may not be awarded a loan. Furthermore, the bill prohibits a council member from receive a loan under the program.

Submission and Review

The bill requires DOH to set revolving loan application periods, up to four per fiscal year. For application periods that feature separate priority tracks for the Council's current focus areas, DOH must coordinate application periods with the Council.

The bill requires DOH to publicize the availability of loans under the Innovation Loan Program.

A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, or service delivery models. The bill authorizes loans for proposals that:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials; or
- Adopt new technologies or systems.

[50] These twenty entities are birth centers, short-term residential treatment facilities, residential treatment facilities, residential treatment centers for children and adolescents, hospitals, ambulatory surgical centers, nursing homes, assisted living facilities, home health agencies, companion services or homemaker services providers, adult day care centers, hospices, adult family-care homes, homes for special services, transitional living facilities, prescribed pediatric extended care centers, home medical equipment providers, intermediate care facilities for persons with development disabilities, and health care clinics.

[51] These five entities are laboratories authorized to perform testing under the Drug-Free Workplace Act, abortion clinics, nurse registries, health care services pools, and organ/tissue/eye procurement organizations.

Each time DOH receives an application during the application period, the bill requires DOH to determine if the application is complete and if the applicant demonstrates the ability to repay the loan.

Within 30 days after an application period closes, the bill requires DOH to forward all complete applications to the Council for consideration. Then, the bill requires the Council to review submitted applications using the criteria and processes and format adopted by the DOH by rule. The Council must prioritize proposals and offer its funding recommendations to DOH.

Loan Awards

The bill requires DOH to award the loans based on demonstrated need and availability of funds.

The bill authorizes DOH to award a revolving loan for up to 50 percent of the total projected implementation costs, or up to 80 percent of the total projected implementation costs for an applicant that is located in a rural or medically underserved area and is either a rural hospital or a nonprofit entity that accepts Medicaid patients.

However, the bill prohibits DOH from awarding more than 10 percent of the total allocated funds for the fiscal year to a single applicant. The bill restricts applicant to one loan award per fiscal year. If the applicant has an outstanding loan, the bill allows that applicant to apply for a new loan only if the outstanding loan is in good standing.

Terms and Conditions

The bill establishes a maximum loan term of 10 years and authorizes a maximum interest rate of 1 percent. The bill requires each loan recipient to enter into written agreements with DOH to receive the loan. At a minimum, the agreement must specify:

- The total amount of the award.
- The performance conditions that must be met, based upon the submitted proposal and the defined category or focus area, as applicable.
- The information to be reported on actual implementation costs, including the share from non-state resources.
- The schedule for payment.
- The data and progress reporting requirements and schedule.[52]
- Any sanctions that would apply for failure to meet performance conditions.

The bill advises that loans become due and payable in accordance with the terms of the written agreement.

The bill requires DOH, upon request, to help loan recipients with technical assistance under the Innovation Loan Program.

Financial Services

The bill requires DOH to create and maintain a separate account in its Grants and Donations Trust Fund for the Innovation Loan Program. This account will receive legislative appropriations, not subject to reversion to the state, for the purpose of underwriting loans and will receive loan repayments of principal. The bill requires DOH to redirect principal to underwrite future loans to successful applicants under the Innovation Loan Program. The bill appropriates $50 million in recurring funds to fund the loan program, and sunsets the program on July 1, 2043.

[52] The bill requires DOH to develop uniform data reporting requirements in order to evaluate the performance of the implemented proposals. The data collected must be shared with the council.

The bill authorizes DOH to contract with a third-party administrator to administer the revolving loan program, including loan servicing, and manage the revolving loan fund. A contract for a third-party administrator must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

Reporting

The bill requires DOH to publish information on its website related to loan recipients, including the written agreements, the performance conditions and status, and the total amount of funds disbursed to date. Information related to a loan must be updated annually on the award date of the loan.

Each September 1, beginning in 2025, DOH must post on its website a report on health care innovation which includes all of the following information:

- A summary of the recommendations that the council adopted and implemented during the previous fiscal year.
- An evaluation of actions and related activities to meet the purposes set forth in the bill.
- Consolidated data based upon the uniform data reporting by funding recipients and an evaluation of how the provision of the loans has met the purposes set forth in the bill.
- The number of applications for loans, the types of proposals received, and an analysis on the relationship between the proposals and the purposes of the bill.
- The amount of funds allocated and awarded for each loan application period, as well as any funds not awarded in that period.
- The amount of funds paid out during the fiscal year and any funds repaid or unused.
- The number of persons assisted and outcomes of any technical assistance requested for loans and any federal, state, or private funding opportunities.

Evaluation

The bill directs the Office of Economic and Demographic Research (EDR)[53] and the Office of Program Policy Analysis and Government Accountability (OPPAGA)[54] to each evaluate specific aspects of the revolving loan program every five years, as follows.

The first report by EDR is due October 1, 2029, which must be a comprehensive financial and economic evaluation of the innovative solutions undertaken by the revolving loan program. The evaluation must include, but is not limited to, separate calculations of the state's return and the economic value to residents of this state and the identification of any cost savings to patients or the state and the impact on the state's health care workforce.

The first report by OPPAGA is due October 1, 2030, which must be an evaluation of the administration and efficiency of the revolving loan program. The evaluation must include, but is not limited to, the degree to which the collective proposals increased efficiency in the health care system in this state, improved patient outcomes, increased public access to health care, and achieved the cost savings identified in the EDR evaluation without reducing the quality of patient care.

[53] EDR is a research arm of the Legislature principally concerned with forecasting economic and social trends that affect policy making, revenues, and appropriations. EDR provides objective information to committee staffs and members of the Legislature in support of the policy making process. EDR publishes all of the official economic, demographic, revenue, and agency workload forecasts that are developed by Consensus Estimating Conferences and makes them available to the Legislature, state agencies, universities, research organizations, and the general public. EDR, through a contract with the University of Florida, arranges for annual estimates of population of each city and county in Florida, which provide the basis for revenue sharing programs.

[54] OPPAGA is a research arm of the Florida Legislature. OPPAGA was created by the Legislature in 1994 to help improve the performance and accountability of state government. OPPAGA provides data, evaluative research, and objective analyses to assist legislative budget and policy deliberations. OPPAGA conducts research as directed by state law, the presiding officers of the Legislature, or the Joint Legislative Auditing Committee.

Each report must include recommendations for consideration by the Legislature.

The bill grants EDR and OPPAGA access to all data necessary to complete their evaluations, including any confidential data. The bill authorizes EDR and OPPAGA to collaborate on data collection and analysis.

The reports must be sent to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Technical Assistance for Funding Opportunities

DOH must identify and publish on its website a list of federal, state, and private sources of funding opportunities available to implement innovative technologies and service delivery models in health care. The information must include details and eligibility requirements for each opportunity. DOH must provide technical assistance to apply for such funding upon request and is encouraged to foster working relationships that will allow the department to refer interested applicants to appropriate contacts for the funding opportunities.

The bill authorizes DOH, notwithstanding the statutory preconditions for emergency rules, to adopt emergency rules to implement this bill. The emergency rules are effective for six months after adoption and may be renewed until permanent rules are adopted pursuant to ch. 120, F.S.

The bill takes effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Upon implementation, the DOH will incur costs to administratively support the council, including travel and per diem expenses of members and website hosting, and to implement and administer the revolving loan program. OPPAGA will incur costs in 2030 and EDR will incur costs in 2029, and every five years thereafter, respectively, to conduct their evaluations of the program.

   The bill appropriates the following to implement its provisions:

   - $250,000 in nonrecurring funds to DOH to implement and administer the Health Care Innovation Council;
   - $1 million in recurring funds to DOH to administer the Council beginning in Fiscal Year 2024-2025; and
   - $50 million in nonrecurring funds for each of the next 10 years, beginning in Fiscal Year 2024-2025, for the revolving loan fund created by the bill.

   The bill allows DOH to use up to 3% of the $50 million in nonrecurring funds set aside each year for the revolving loan fund to cover the administrative costs of implementing the revolving loan program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If the program is implemented, loan awardees will be able to pursue innovative health care solutions, which may have a positive economic impact on the recipients and the health care system as a whole.

D. FISCAL COMMENTS:

None.