Tab 1	**SB 1606** by **Grall;** Similar to CS/H 01083 Patient Access to Records

332792	A	S	RCS	HP, Grall	Delete L.59 - 250:	04/02 01:12 PM
900268	A	S	RS	HP, Grall	Delete L.463 - 474.	04/02 01:12 PM
894726	SA	S	RCS	HP, Grall	Delete L.463 - 511:	04/02 01:12 PM

Tab 7	**SB 22** by **Rodriguez;** Identical to CS/H 06525 Relief of Eric Miles, Jr., and Jennifer Miles by the South Broward Hospital District

Tab 8	**SB 28** by **Martin;** Similar to H 06523 Relief of Darline Angervil and J.R. by the South Broward Hospital District

883178	A	S	RCS	HP, Martin	Delete L.142 - 143:	04/02 01:12 PM

Tab 9	**SB 306** by **Sharief (CO-INTRODUCERS) Gaetz, Davis;** Identical to H 00389 Managed Care Plan Network Access

931448	D	S	RCS	HP, Sharief	Delete everything after	04/02 01:12 PM

Tab 10	**SB 1270** by **Collins;** Compare to CS/H 01085 Department of Health

275506	D	S	RCS	HP, Collins	Delete everything after	04/02 01:04 PM
978704	AA	S	RCS	HP, Collins	btw L.792 - 793:	04/02 01:04 PM
159816	AA	S	RCS	HP, Collins	Delete L.1315 - 1316:	04/02 01:04 PM

Tab 11	**CS/SB 772** by **ED, Calatayud;** Similar to CS/CS/CS/H 00597 Diabetes Management in Schools

Tab 12	**SB 998** by **Calatayud;** Compare to CS/H 00647 Physician Assistant and Advanced Practice Registered Nurse Services

475642	A	S	RCS	HP, Calatayud	Delete L.93 - 183.	04/02 01:12 PM

Tab 13	**SB 1412** by **Calatayud;** Similar to CS/H 01353 Home Health Care Services

Tab 14	**SB 1800** by **Calatayud;** Compare to CS/H 01545 Parkinson's Disease Research Funding

614080	D	S	RCS	HP, Calatayud	Delete everything after	04/02 01:12 PM

Tab 15	**SB 596** by **Leek;** Similar to H 00427 Cardiac Services Providers

Tab 16	**SB 1768** by **Trumbull;** Similar to H 01617 Stem Cell Therapy

947004	D	S	RCS	HP, Trumbull	Delete everything after	04/02 01:12 PM

Tab 17	**SB 1602** by **Harrell;** Similar to CS/H 01119 Health Care Patient Protection

722464	A	S	RCS	HP, Harrell	Delete L.55 - 110:	04/02 01:12 PM

Tab 18	**SB 1156** by **Harrell;** Similar to CS/H 01529 Home Health Aide for Medically Fragile Children Program

735504	D	S	RCS	HP, Harrell	Delete everything after	04/02 01:12 PM

Tab 19	**SB 1490** by **Harrell;** Similar to CS/H 01085 Children's Medical Services Program

865162	A	S	RCS	HP, Harrell	Delete L.102 - 691:	04/02 01:12 PM

Tab 20	**SB 1182** by **Harrell;** Identical to CS/H 01465 Medicaid Coverage of Continuous Glucose Monitors

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Harrell, Vice Chair

MEETING DATE: Tuesday, April 1, 2025
TIME: 1:30—3:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Burton, Chair; Senator Harrell, Vice Chair; Senators Berman, Calatayud, Davis, Gaetz, Leek, Osgood, Passidomo, and Trumbull

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	Pending Reconsideration:		
1	**SB 1606** Grall (Identical H 1083)	Patient Access to Records; Requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request for such records; revising provisions relating to the appropriate disclosure of patient records without consent; revising the timeframe within which a nursing home facility must provide access to and copies of resident records after receiving a request for such records; authorizing a provider to impose reasonable terms necessary to preserve such records, etc. HP 03/25/2025 Pending reconsideration (Unfavorable) HP 04/01/2025 Reconsidered (Fav/CS) AHS RC	Motion to Reconsider Adopted -- Final Vote: Fav/CS Yeas 7 Nays 3

TAB	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION
	Senate Confirmation Hearing: A public hearing will be held for consideration of the below-named executive appointments to the offices indicated.		
	Secretary of Health Care Administration		
2	Harris, Shevaun ()	Pleasure of Governor	Recommend Confirm Yeas 9 Nays 0
	Board of Chiropractic Medicine		
3	Baum, Howard Wesley III (Brandon)	10/31/2025	Recommend Confirm Yeas 9 Nays 0
	Saunders, Gretchen Y. (Spring Hill)	10/31/2027	Recommend Confirm Yeas 9 Nays 0
	Oliverio, Anthony B. (Crystal River)	10/31/2028	Recommend Confirm Yeas 9 Nays 0
	Comerford, Jason (Palm Bay)	10/31/2028	Recommend Confirm Yeas 9 Nays 0
	Board of Medicine		
4	Ackerman, Scot N. ()	10/31/2026	Recommend Confirm Yeas 9 Nays 0

TAB	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION
	Vila, Hector, Jr. (Tampa)	10/31/2026	Recommend Confirm Yeas 9 Nays 0
	Knight, James Matthew (Winter Park)	10/31/2027	Recommend Confirm Yeas 9 Nays 0
	Christie, Steven (Key Biscayne)	10/31/2027	Recommend Confirm Yeas 9 Nays 0
	Board of Optometry		
5	Burns-LeGros, Denise (Indialantic)	10/31/2027	Recommend Confirm Yeas 9 Nays 0
	Stam, Bryan (Ponte Vedra Beach)	10/31/2027	Recommend Confirm Yeas 9 Nays 0
	Easton, Robert, Jr. (Oakland Park)	10/31/2028	Recommend Confirm Yeas 9 Nays 0
	Board of Physical Therapy Practice		
6	Cirolia, Jason (Ormond Beach)	10/31/2026	Recommend Confirm Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 22** Rodriguez (Identical CS/H 6525)	Relief of Eric Miles, Jr., and Jennifer Miles by the South Broward Hospital District; Providing for the relief of Eric Miles, Jr., and Jennifer Miles, as copersonal representatives of their minor son, E.E.M., by the South Broward Hospital District, d/b/a Joe DiMaggio Children's Hospital; providing for an appropriation to compensate Eric Miles, Jr., and Jennifer Miles for the injuries and damages sustained by their son as a result of the negligence of the South Broward Hospital District; providing a limitation on compensation and the payment of attorney fees, etc. SM JU 03/19/2025 Favorable HP 04/01/2025 Favorable RC	Favorable Yeas 9 Nays 1
8	**SB 28** Martin (Similar H 6523)	Relief of Darline Angervil and J.R. by the South Broward Hospital District; Providing for the relief of Darline Angervil and J.R., a minor, by the South Broward Hospital District; providing an appropriation to compensate Darline Angervil, individually and as parent and natural legal guardian of J.R., for injuries and damages sustained as a result of negligence of the South Broward Hospital District; providing a limitation on compensation and the payment of attorney fees, etc. SM JU 03/25/2025 Favorable HP 04/01/2025 Fav/CS RC	Fav/CS Yeas 9 Nays 1

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
9	**SB 306** Sharief (Identical H 389)	Managed Care Plan Network Access; Requiring that the Agency for Health Care Administration include specified requirements in its contracts with Medicaid managed care plans; authorizing enrollees of Medicaid managed care plans to receive care from Medicaid providers not under contract with the plan under certain circumstances, etc. HP 04/01/2025 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 0
10	**SB 1270** Collins (Compare CS/H 1085, CS/H 1299, S 1166, S 1490)	Department of Health; Repealing a provision which provides for the repeal of the definition of the term "messenger ribonucleic acid vaccine"; deleting the requirement that all officers and board members of medical marijuana treatment centers pass a background screening; repealing provisions relating to the developmental disability information clearinghouse and advisory council, the Diabetes Advisory Council, the Statewide Children's Medical Services Network Advisory Council, and the Statewide Drug Policy Advisory Council, respectively; revising eligibility criteria for licensure by endorsement under the MOBILE Act; repealing a provision relating to the Board of Orthotists and Prosthetists, etc. HP 04/01/2025 Fav/CS AHS FP	Fav/CS Yeas 6 Nays 3
11	**CS/SB 772** Education Pre-K - 12 / Calatayud (Similar CS/CS/H 597)	Diabetes Management in Schools; Authorizing a school district or public school to acquire and maintain a supply of undesignated glucagon; authorizing a school district or public school to obtain monetary donations or apply for grants to purchase glucagon; authorizing a school district or public school to request a prescription for glucagon from a county health department; requiring an employee to call for emergency assistance and provide parental notification after the administration of glucagon, etc. ED 03/17/2025 Fav/CS HP 04/01/2025 Favorable RC	Favorable Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
12	**SB 998** Calatayud (Compare CS/H 647)	Physician Assistant and Advanced Practice Registered Nurse Services; Revising who may file a certificate of death or fetal death; revising who may note corrected information on a permanent certificate of death or fetal death; revising the roles and responsibilities of the plan of care team in hospice programs, etc. HP 04/01/2025 Fav/CS AHS RC	Fav/CS Yeas 10 Nays 0
13	**SB 1412** Calatayud (Identical H 1353)	Home Health Care Services; Deleting geographical limitations on the home health agencies that an administrator may manage at any given time; deleting a requirement that, under certain circumstances, a home health agency provide the initial admission visit, service evaluation visits, and the discharge visit to admitted patients by a direct employee; revising the eligibility criteria for awards under the Excellence in Home Health Program, etc. HP 04/01/2025 Favorable AHS RC	Favorable Yeas 10 Nays 0
14	**SB 1800** Calatayud (Compare CS/H 1545, H 1547, Linked S 1802)	Parkinson's Disease Research Funding; Creating the "Parkinson's Disease Research Fund Act"; establishing the Parkinson's Disease Research Program; requiring the Department of Health to create a specified registry; requiring the Department of Health to establish the Parkinson's Disease Research Advisory Board, etc. HP 04/01/2025 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 0
15	**SB 596** Leek (Similar H 427)	Cardiac Services Providers; Revising requirements for licensure of Level I and Level II adult cardiovascular programs; requiring the Agency for Health Care Administration to update specified rules as new applicable industry standards and guidelines are published, etc. HP 04/01/2025 Temporarily Postponed AHS FP	Temporarily Postponed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
16	**SB 1768** Trumbull (Similar H 1617)	Stem Cell Therapy; Authorizing health care providers to perform stem cell therapy not approved by the United States Food and Drug Administration under certain circumstances; requiring health care providers to provide a specified written notice to patients before performing any stem cell therapy; requiring health care providers to obtain written consent from the patient or his or her representative before performing the therapy, etc. HP 04/01/2025 Fav/CS AHS RC	Fav/CS Yeas 10 Nays 0
17	**SB 1602** Harrell (Similar CS/H 1119)	Health Care Patient Protection; Requiring hospital emergency departments to develop and implement policies and procedures, conduct training, record weights in a certain manner, designate a pediatric emergency care coordinator, and conduct specified assessments; requiring the agency to adopt certain rules for comprehensive emergency management plans, and, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, establish minimum standards for pediatric patient care in hospital emergency departments; requiring the agency to collect and publish the results of specified assessments submitted by hospitals by specified dates, etc. HP 04/01/2025 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 0
18	**SB 1156** Harrell (Similar CS/H 1529, Compare S 1166)	Home Health Aide for Medically Fragile Children Program; Specifying that services provided by a home health aide for a medically fragile child may not exceed a specified percentage of the total annual hours authorized for private duty nursing services for that child; revising requirements for the Medicaid fee schedule for home health aides for medically fragile children; requiring the Agency for Health Care Administration, within a specified timeframe, to seek federal approval to implement specified practices under the program, etc. HP 04/01/2025 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
19	**SB 1490** Harrell (Similar CS/H 1085, S 1166, Compare S 1270)	Children's Medical Services Program; Transferring operation of the Children's Medical Services Managed Care Plan from the Department of Health to the Agency for Health Care Administration, effective on a specified date; requiring the agency to seek federal approval to amend the state's Medicaid Model Waiver for home and community-based services to include certain services; requiring the CMS program to conduct clinical eligibility screening for certain children and youth with special health care needs; revising the purposes and functions of the CMS program, etc. HP 04/01/2025 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 0
20	**SB 1182** Harrell (Identical CS/H 1465)	Medicaid Coverage of Continuous Glucose Monitors; Requiring the Agency for Health Care Administration to, within a specified timeframe, seek federal approval as needed to provide coverage of continuous glucose monitors and related supplies as a durable medical equipment benefit under the Medicaid program; requiring the agency to implement these changes upon receiving any necessary federal approval, etc. HP 04/01/2025 Favorable AHS FP	Favorable Yeas 10 Nays 0
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1606
INTRODUCER:	Health Policy Committee and Senator Grall
SUBJECT:	Patient Access to Records
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.			AHS	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

Under current Florida law, hospitals, ambulatory surgical centers, and health care practitioners are required to provide requested patient health records to patients, residents, and their legal representatives in a "timely" manner. In the absence of a specific statutory deadline, the federal Health Insurance Portability and Accountability Act (HIPAA) standard of 30 calendar days applies. For electronic health information, the federal Information Blocking Rule also generally applies, requiring access without unreasonable delay.

CS/SB 1606 standardizes the timeframe for responding to patient records requests for patients, residents, and their legal representatives. The bill amends various sections of the Florida Statutes to require health care providers and practitioners to furnish requested records within 14 working days of a request. Providers and practitioners who maintain electronic health record systems must deliver the records in the format chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the service provider maintains a patient portal.

In addition, the bill requires providers and practitioners to allow access for the inspection of original records, or suitable reproductions such as microforms, within 10 working days of receiving a request. Providers may impose reasonable conditions to protect the integrity of the records.

The bill creates s. 408.833, F.S., to establish uniform record access and delivery standards for clients of health care providers (including facilities) that are licensed, registered, or certified by the Agency for Health Care Administration (AHCA), that are not otherwise addressed in specific statutory provisions. These standards are also applied to licensed health care practitioners regulated by the Department of Health (DOH), as well as to mental health service providers and substance abuse treatment providers.

Florida law currently requires nursing homes to provide requested records within 14 working days. The bill revises this requirement to align with federal Medicare and Medicaid Conditions of Participation, mandating that inspection be allowed within 24 hours (excluding weekends and holidays) and copies be furnished within two working days of the request.

The bill provides an effective date of January 1, 2026.

II. Present Situation:

Federal Right of Access to Records Under HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) establishes national standards for the protection of individually identifiable health information. The HIPAA Privacy Rule[1], implements these protections and sets forth the individual right of access to medical records.[2] The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) is responsible for implementing and enforcing the HIPAA Privacy Rule.[3]

Under the Privacy Rule, individuals have the right to inspect or obtain a copy of their *protected health information* (PHI) maintained by a *covered entity*. Covered entities include:

- Health care providers who transmit health information electronically in connection with certain administrative transactions,
- Health plans such as insurers and health maintenance organizations (HMOs), and
- Health care clearinghouses.[4]

Most licensed health care providers and health care practitioners in Florida qualify as covered entities under these definitions. Business associates of covered entities, such as third-party billing companies or cloud storage providers, must also comply with HIPAA's access provisions when they handle protected health information on behalf of the covered entity.[5]

The Privacy Rule requires covered entities to provide access to PHI contained in what is known as a *designated record set*. A designated record set is defined[6] as a group of records maintained by or for a covered entity that is used, in whole or in part, to make decisions about individuals. These records include:

[1] 45 C.F.R. Part 160 and Subparts A and E of Part 164.
[2] 45 C.F.R. § 164.524.
[3] U.S. Department of Health and Human Services, Office for Civil Rights, *Summary of the HIPAA Privacy Rule, available at:* https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (last visited Mar. 22, 2025).
[4] 45 C.F.R. § 160.103.
[5] 45 C.F.R. §§ 160.103, 164.502(e).
[6] 45 C.F.R. § 164.501.

- Medical and billing records maintained by or for a health care provider,
- Enrollment, payment, claims adjudication, and case or medical management records maintained by or for a health plan, and
- Any other records used to make decisions about the individual. [7]

Records not used to make treatment or coverage decisions—such as peer review files or internal administrative documents—are not considered to be included in the designated record set.

The Privacy Rule requires covered entities to respond to a request for access within *30 calendar days*.[8] One 30-day extension is permitted if the individual is notified in writing of the delay and the expected response date.[9] If PHI is maintained electronically, and the individual requests an electronic copy, the entity must provide it in the requested form and format if it is readily producible.[10]

Covered entities may charge only a *reasonable, cost-based fee* for access. This fee may include the cost of labor for copying, supplies, and postage, if applicable, but may not include retrieval fees or other administrative charges.[11] In guidance issued by the OCR, covered entities are prohibited from imposing barriers to access, such as requiring patients to submit requests in person or through proprietary forms when such requirements are not necessary.[12]

Interaction of HIPAA with State Law[13]

HIPAA establishes a national baseline for the privacy and security of health information but permits states to enact laws that provide greater protections or access rights. A state law is only preempted by HIPAA if it is contrary to HIPAA—that is, if it is impossible to comply with both the state and federal requirements, or if the state law stands as an obstacle to the full purposes and objectives of HIPAA.

However, if a state law is more protective of patient privacy or provides greater access to health information than HIPAA, it is not preempted and remains enforceable. In practice, this means states may adopt laws that expand individual rights of access, shorten response times, or add safeguards, so long as they do not authorize disclosures or impose barriers that conflict with HIPAA's requirements.

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[7] *Id.*
[8] The OCR has recently considered reducing this time frame to 15 days in a proposed rule modification, but the rule was not finalized. U.S. Department of Health and Human Services, *Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement*, 86 Fed. Reg. 6446 (Jan. 21, 2021), *available at* https://www.govinfo.gov/content/pkg/FR-2021-01-21/pdf/2020-27157.pdf.
[9] 45 C.F.R. § 164.524(b)(2).
[10] 45 C.F.R. § 164.524(c)(2).
[11] 45 C.F.R. § 164.524(c)(4).
[12] U.S. Department of Health and Human Services, Office for Civil Rights, *Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524*, *available at*: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html (last visited Mar. 22, 2025).
[13] U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, When a state or federal law or regulation (such as the HIPAA Privacy Rule) requires that EHI be released, is it ever information blocking not to release it?, *available at*: https://www.healthit.gov/faq/when-state-or-federal-law-or-regulation-such-hipaa-privacy-rule-requires-ehi-be-released-no (last visited Mar. 22, 2025).

Federal Information Blocking Prohibition

The 21st Century Cures Act[14] prohibits certain actors from engaging in "*information blocking*," which is broadly defined as any practice that is likely to interfere with access, exchange, or use of *electronic health information* (EHI), unless the practice is required by law or covered by a regulatory exception.[15] The Office of the National Coordinator for Health Information Technology (ONC) is responsible for implementing the rule,[16] and the U.S. Department of Health and Human Services Office of Inspector General (OIG) is charged with enforcement.[17]

The federal Information Blocking Rule[18], adopted by ONC in 2020, applies to three categories of actors:

- Health care providers,
- Developers of certified health information technology (health IT), and
- Health information networks or health information exchanges.[19]

Most licensed health care providers and health care practitioners in Florida fall within the rule's definition of a "health care provider."[20]

The rule prohibits these actors from engaging in practices that are "likely to interfere" with access, exchange, or use of EHI, unless one of eight specified exceptions applies.[21] EHI is defined to include all electronic protected health information (ePHI) that would be part of a designated record set under HIPAA.[22] Examples of information blocking may include imposing unnecessary delays, refusing to provide records in electronic format, charging unreasonable fees, or using technology in a way that restricts access or interoperability.

Unlike HIPAA, which allows covered entities to respond to access requests within 30 calendar days, the Information Blocking Rule requires that access to EHI be provided *without unreasonable delay*, subject to specified exceptions where the EHI is protected.[23] These include exceptions for preventing harm, protecting privacy, ensuring security, managing infeasible requests, maintaining health IT performance, complying with licensing restrictions, and limiting the manner of access.[24]

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[14] Pub. L. No. 114-255.
[15] 42 U.S.C. § 300jj-52.
[16] U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *Information Blocking Overview*, *available at:* https://www.healthit.gov/topic/information-blocking (last visited Mar. 22, 2025).
[17] U.S. Department of Health and Human Services, Office of Inspector General, *Information Blocking Enforcement*, *available at*: https://oig.hhs.gov/reports/featured/information-blocking/ (last visited Mar. 22, 2025).
[18] 45 C.F.R. Part 171.
[19] 45 C.F.R. § 171.102.
[20] "Health care provider" for purposes of the Information Blocking Rule has the same meaning as "health care provider" in 42 U.S.C. § 300jj.
[21] 45 C.F.R. § 171.103.
[22] *See* 45 C.F.R. § 171.102, referencing 45 C.F.R. § 164.501.
[23] 45 C.F.R. §§ 171.200–171.303.
[24] *Id.*

Enforcement of the Information Blocking Rule is governed by 42 U.S.C. § 300jj-52(b). OIG may impose civil monetary penalties of up to $1 million per violation on health IT developers and health information networks or exchanges. While ONC and OIG have finalized enforcement regulations for non-provider actors, enforcement policies for health care providers are still forthcoming as of early 2025.

Interaction of the Information Blocking Rule with State Law

The federal law preempts state law only to the extent of a direct conflict.

> *"The information blocking provisions of the Cures Act establish a floor for permissible practices and do not preempt State laws that are more stringent."*
> — 85 Fed. Reg. 25810 (May 1, 2020).

The Information Blocking Rule does not prohibit state laws that impose stricter or faster access obligations but does preempt state laws that would require or permit practices that interfere with access to EHI in ways that federal law would otherwise prohibit.

The ONC has clarified that compliance with state law is not a defense to information blocking if the delay or interference is not required by the state law. This is central to understanding how federal and state requirements interact:

> *"The fact that an actor covered by the information blocking regulations meets its obligations under another law applicable to them or its circumstances (such as the maximum allowed time an actor has under that law to respond to a patient's request) will not automatically demonstrate that the actor's practice does not implicate the information blocking definition."*
> — ONC Information Blocking FAQ.[25]

This means that a state statute may impose a 14-day deadline, but if a provider routinely waits 14 days to respond when it could have provided access sooner, that practice may still constitute information blocking.

Due to the many provider types affected by changes made by the bill, pertinent background information regarding Florida law is provided within the Effect of Proposed Changes section of this analysis for the reader's convenience.

[25] U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *When a state or federal law or regulation (such as the HIPAA Privacy Rule) requires that EHI be released, is it ever information blocking not to release it?, available at*: https://www.healthit.gov/faq/when-state-or-federal-law-or-regulation-such-hipaa-privacy-rule-requires-ehi-be-released-no (last visited Mar. 22, 2025).

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 394.4615, F.S., to require a **mental health service provider**[26] to furnish copies of clinical records[27] within 14 working days of receiving a request, if:

- The patient or the patient's guardian[28] or legal custodian authorizes the release;
- The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation; or
- The court orders the release.

Under the bill, a service provider may furnish the requested clinical records in paper form or, upon request, in an electronic format. If the service provider maintains an electronic health record system, the service provider must furnish the clinical records in the format chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the service provider maintains a patient portal.

Section 2 of the bill amends s. 395.3025, F.S., to remove the requirement that **licensed hospitals and ambulatory surgical centers** timely provide patient records only after a patient's discharge, thereby aligning state law with federal access rights under HIPAA.

Section 2 also changes the term "agency" (as in the Agency for Health Care Administration) to "Department of Health" and "department" to clarify[29] and correct[30] that the DOH has the authority to issue subpoenas for patient records from entities regulated under ch. 395, F.S., for the purposes of investigating a health care practitioner.

To conform to changes made by the bill this section also deletes language requiring a licensed hospital or ambulatory surgical center to allow a person to examine original records in its possession, or microforms or other suitable reproductions of the records. The requirements in the deleted text would instead be applied to licensed hospitals and ambulatory surgical centers in s. 408.833, F.S., as created in section 5 of the bill, on lines 215-221.

As a federal condition of a hospital's participation in Medicare or Medicaid, a hospital must provide access to requested patient records "within a reasonable time frame" and to "seek to

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[26] "Service provider" means a receiving facility, a facility licensed under ch. 397, F.S., a treatment facility, an entity under contract with the Department of Children and Families to provide mental health or substance abuse services, a community mental health center or clinic, a psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatrist, an advanced practice registered nurse, a psychiatric nurse, or a qualified professional as defined in s. 39.01, F.S. Section 394.455(45), F.S.

[27] "Clinical record" means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by facility staff which pertains to the patient's hospitalization or treatment. Section 394.455(6), F.S.

[28] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(18), F.S.

[29] Department of Health, Senate Bill 1606 Legislative Analysis (Mar. 20, 2025) (on file with the Senate Committee on Health Policy).

[30] Agency for Health Care Administration, Senate Bill 1606 Legislative Analysis (Mar. 19, 2025) (on file with the Senate Committee on Health Policy).

fulfill requests as quickly as their recordkeeping system permits."[31] This requirement exists in conjunction with Florida law and would continue to apply under the bill.

Section 3 of the bill amends s. 397.501, F.S., to require **substance abuse service providers** to furnish copies of records within 14 working days after receiving a *written* request from an individual or the individual's legal representative.[32]

If the service provider maintains an electronic health record system, the service provider must furnish the requested records in the format chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the service provider maintains a patient portal.

The service provider must, within 10 working days after receiving such a written request from an individual or his or her legal representative, provide access to examine the original records in the service provider's possession, or microforms, or other suitable reproductions of the records. The service provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

Section 4 of the bill amends s. 400.145, F.S., to revise the timeframe within which **nursing home facilities** must provide access to and copies of resident records upon written request.[33] Current law requires a nursing home facility to provide the requested records within 14 working days after receiving a written request relating to current resident. Under the bill, for current residents, access must be provided within 24 hours (excluding weekends and holidays), and copies must be provided within two working days, of receipt of the written request. This change would align Florida law with federal law for nursing home facilities that receive Medicare or Medicaid funding.[34]

For former residents, copies must be provided within 30 working days. The bill does not make changes to the timeline for requests from former residents.

Section 5 of the bill creates s. 408.833, F.S., within the Health Care Licensing Procedures Act[35] to establish uniform standards for record access by clients[36] of **health care providers**,[37]

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[31] *See* 42 CFR § 482.24(b)(3) and 42 C.F.R. § 482.13(d)(2).
[32] For purposes of this section, the term "legal representative" has the same meaning as in s. 408.833(1), F.S., as created in section 5 of the bill.
[33] Note that access to assisted living facility resident records is also governed by this section in current law. *See* changes made to s. 429.294, F.S., in section 11 of the bill.
[34] 42 C.F.R. § 483.10(g)(2)(ii) requires Medicare- or Medicaid-certified long-term care facilities to provide residents or their legal representatives the opportunity to inspect all records, including clinical records, within 24 hours (excluding weekends and holidays) of an oral or written request.
[35] Chapter 408, Part II, F.S. *See also* s. 408.801(1), F.S.
[36] "Client" means any person receiving services from a provider listed in s. 408.802. Section 408.803(6), F.S.
[37] The Act applies to all of the following facilities: Laboratories authorized to perform testing under the Drug-Free Workplace Act; birth centers; abortion clinics; crisis stabilization units; 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; nurse registries; 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

including facilities, that are licensed, registered, or certified by the AHCA and not otherwise addressed in statute. Records maintained by psychiatric hospitals, substance abuse treatment providers, or nursing homes are exempt from this section pursuant to subsection (4).

The section defines the term "legal representative" as an attorney who has been designated by a client to receive copies of the client's medical, care and treatment, or interdisciplinary records; a legally recognized guardian of the client; a court-appointed representative of the client; or a person designated by the client or by a court of competent jurisdiction to receive copies of the client's medical, care and treatment, or interdisciplinary records.

The bill requires providers to furnish records within 14 working days after receiving a *written* request from a client or his or her legal representative. A provider must furnish *all* records in the provider's possession, including, but not limited to: medical, care and treatment, and interdisciplinary records.

A provider may furnish the requested records in paper form or, upon request, in an electronic format. If the health care practitioner maintains an electronic health record system, the service provider must furnish the requested records in the format chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the service provider maintains a patient portal.

The health care provider must, within 10 working days after receiving a request from an individual or his or her legal representative, provide access to examine the original records in the service provider's possession, or microforms, or other suitable reproductions of the records. The health care provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

A **hospice** would be required to follow this section of law. However, pursuant to s. 400.611(4), F.S., a hospice may not release a patient's interdisciplinary record or any portion of it, unless the person requesting the information provides a patient authorization or other satisfactory documentation in compliance with that section.

Section 6 of the bill amends s. 456.057, F.S., to require **any health care practitioner**[38] licensed by the DOH who is not exempt under subsection (2)[39] to furnish copies of requested records

developmental disabilities; health care services pools; health care clinics; and organ, tissue, and eye procurement organizations. Section 408.802, F.S. *See also* s. 408.803(12), F.S.

[38] Acupuncturists; allopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants; osteopathic physicians, physician assistants, and anesthesiologist assistants; chiropractic physicians and physician assistants; podiatric physicians; naturopathic physicians; optometrists; autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses, and certified nursing assistants; pharmacists, pharmacy interns, and pharmacy technicians; dentists, dental hygienists, and dental laboratories; midwives; speech and language pathologists; audiologists; occupational therapists and occupational therapy assistants; respiratory therapists; dieticians and nutritionists; athletic trainers; orthotists, prosthetists, and pedorthists; electrologists; massage therapists; clinical laboratory personnel; medical physicists; genetic counselors; opticians; hearing aid specialists; physical therapists; psychologists and school psychologists; and clinical social workers, mental health counselors, and marriage and family therapists.

[39] The following persons are not included for purposes of that section: certified nursing assistants, pharmacists and pharmacies, dental hygienists, nursing home administrators, respiratory therapists, athletic trainers, electrologists, clinical

within 14 working days after the request is received, rather than "in a timely manner, without delays for legal review" as written in current law. This creates a specific timeframe in which health care practitioners must remit the requested records to the patient or his or her legal representative.

For health care practitioners, records include any report or record relating to examination or treatment of the patient.

If the health care practitioner maintains an electronic health record system, the service provider must furnish the requested records in the format chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the service provider maintains a patient portal.

The bill creates a definition for the term "legal representative" that is similar to the definition created for health care providers earlier in the bill. Under the bill and for this section, "legal representative" means a *patient's* attorney who has been designated by the patient to receive copies of the patient's medical records, a legally recognized guardian of the patient, a court-appointed representative of the patient, or any other person designated by the patient or by a court of competent jurisdiction to receive copies of the patient's medical records.

The health care practitioner provider must, within 10 working days after receiving a *written* request from an individual or his or her legal representative, provide access to examine the original records in the service provider's possession, or microforms, or other suitable reproductions of the records. The health care practitioner may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

Sections 7, 8, 9, 11, and 12 of the bill amend ss. 316.1932, 316.1933, 395.4025, 440.185, and 456.47, F.S., respectively to revise cross-references to conform to the renumbering of subsections within s. 395.3025, F.S., in section 2 of the bill.

Section 10 of the bill amends s. 429.294, F.S., to conform a cross-reference to changes made in the bill so that access to assisted living facility resident records is governed by s. 408.833, F.S., as created in section 5 of the bill, rather than s. 400.145, F.S.

Section 13 of the bill provides an effective date of January 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

laboratory personnel, medical physicists, opticians and optical establishments, and persons or entities practicing under s. 627.736(7), F.S.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

While a 14-day deadline for responding to records requests is not in conflict with the federal Information Blocking Rule, compliance with that statutory deadline alone may not be enough to shield a provider from liability under federal law if a delay is otherwise unreasonable.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Lines 152 and 204 respectively require that substance abuse service providers and health care providers furnish a true and correct copy of all records in the possession of the provider rather than a true and correct copy of all *requested* records in the possession of the provider. If this is unintended, an amendment should be considered to add the word "requested" before "records."

The bill also requires health care providers, health care practitioners, mental health service providers, and substance abuse service providers that maintain an electronic health record system to furnish clinical records in a format chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the service provider maintains a patient portal. If a requester chooses an abstract electronic format that is contrary to the file format in which the provider or practitioner maintains the files, and which cannot easily be converted into the requested electronic format, this formatting requirement may be unnecessarily burdensome on the provider or practitioner.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.4615, 395.3025, 397.501, 400.145, 456.057, 316.1932, 316.1933, 395.4025, 429.294, 440.185, and 456.47.

This bill creates section 408.833 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on March 25, 2025:
The CS revises the requirement for health care providers and practitioners furnishing records pursuant to a request in the manner chosen by the requester. Under the CS, this includes, but is not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the provider maintains a patient portal. This clarifies that providers and practitioners that do not maintain a patient portal are not required to implement a patient portal to comply with the requirements of the bill.

The CS deletes a cross-reference within s. 400.0234, F.S., which was mistakenly included in the underlying bill. The CS also changes the effective date of the bill from July 1, 2025, to January 1, 2026.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

332792

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
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The Committee on Health Policy (Grall) recommended the following:

Senate Amendment

Delete lines 59 - 250
and insert:
requested records in the manner chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the service provider maintains a patient portal.

Section 2. Subsections (1), (2), and (3), paragraph (e) of


332792

subsection (4), paragraph (a) of subsection (7), and subsection (8) of section 395.3025, Florida Statutes, are amended to read:

395.3025 Patient and personnel records; copy costs ~~copies~~; examination.—

(1) ~~Any licensed facility shall, upon written request, and only after discharge of the patient, furnish, in a timely manner, without delays for legal review, to any person admitted therein for care and treatment or treated thereat, or to any such person's guardian, curator, or personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor, or to anyone designated by such person in writing, a true and correct copy of all patient records, including X rays, and insurance information concerning such person, which records are in the possession of the licensed facility, provided the person requesting such records agrees to pay a charge.~~ The exclusive charge for copies of patient records may include sales tax and actual postage, and, except for nonpaper records that are subject to a charge not to exceed $2, may not exceed $1 per page. A fee of up to $1 may be charged for each year of records requested. These charges shall apply to all records furnished, whether directly from the facility or from a copy service providing these services on behalf of the facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search. ~~The licensed facility shall further allow any such person to examine the original records in its possession, or microforms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to assure that the records will not be~~



~~damaged, destroyed, or altered.~~

~~(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.~~

~~(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.~~

(2)~~(4)~~ Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:

(e) The Department of Health ~~agency~~ upon subpoena issued pursuant to s. 456.071, but the records obtained thereby must be used solely for the purpose of the department ~~agency~~ and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the department ~~agency~~ requests copies of the records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records must be sealed and must not be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor may they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department ~~agency~~ or the appropriate regulatory board. However, the department ~~agency~~ must make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the



determination of probable cause.

(5)(a) ~~(7)(a)~~ If the content of any record of patient treatment is provided under this section, the recipient~~, if other than the patient or the patient's representative,~~ may use such information only for the purpose provided and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose. The content of such patient treatment record is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(6) ~~(8)~~ Patient records at hospitals and ambulatory surgical centers are exempt from disclosure under s. 119.07(1), except as provided by subsections (2) and (3) ~~(1)-(5)~~.

Section 3. Present paragraphs (a) through (j) of subsection (7) of section 397.501, Florida Statutes, are redesignated as paragraphs (c) through (l), respectively, and new paragraphs (a) and (b) are added to that subsection, to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(7) RIGHT TO ACCESS AND CONFIDENTIALITY OF INDIVIDUAL RECORDS.—

(a) Within 14 working days after receiving a written request from an individual or an individual's legal representative, a service provider shall furnish a true and



correct copy of all records in the possession of the service provider. The service provider may furnish the requested records in paper form or, upon request, in an electronic format. A service provider that maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the service provider maintains a patient portal. For purposes of this section, the term "legal representative" has the same meaning as provided in s. 408.833(1).

(b) Within 10 working days after receiving such a request from an individual or an individual's legal representative, a service provider shall provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. The service provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

Section 4. Subsection (1) of section 400.145, Florida Statutes, is amended to read:

400.145 Copies of records of care and treatment of resident.—

(1) Upon receipt of a written request that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this section, a nursing home facility shall furnish to a competent resident, or to a representative of that resident who is authorized to make requests for the resident's records under HIPAA or subsection (2), copies of the resident's paper and electronic records that are in possession of the


332792

facility. Such records must include any medical records and records concerning the care and treatment of the resident performed by the facility, except for progress notes and consultation report sections of a psychiatric nature. The facility shall provide a resident with access to the requested records within 24 hours, excluding weekends and holidays, and provide copies of the requested records within 2 ~~14~~ working days after receipt of a request relating to a current resident or within 30 working days after receipt of a request relating to a former resident.

Section 5. Section 408.833, Florida Statutes, is created to read:

408.833 Client access to medical records.—

(1) For purposes of this section, the term "legal representative" means an attorney who has been designated by a client to receive copies of the client's medical, care and treatment, or interdisciplinary records; a legally recognized guardian of the client; a court-appointed representative of the client; or a person designated by the client or by a court of competent jurisdiction to receive copies of the client's medical, care and treatment, or interdisciplinary records.

(2) Within 14 working days after receiving a written request from a client or client's legal representative, a provider shall furnish a true and correct copy of all records, including medical, care and treatment, and interdisciplinary records, as applicable, in the possession of the provider. A provider may furnish the requested records in paper form or, upon request, in an electronic format. A provider that maintains an electronic health record system shall furnish the requested

332792

records in the manner chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the provider maintains a patient portal.

(3) Within 10 working days after receiving a request from a client or a client's legal representative, a provider shall provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. A provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

(4) This section does not apply to:

(a) Records maintained at a licensed facility, as defined in s. 395.002, the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by s. 394.4615;

(b) Records of substance abuse impaired persons which are governed by s. 397.501; or

(c) Records of a resident of a nursing home facility.

Section 6. Subsection (6) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(6)(a) Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any patient ~~person~~ shall, upon request of such


332792

patient ~~person~~ or the patient's ~~person's~~ legal representative, furnish, within 14 working days after such request ~~in a timely manner, without delays for legal review~~, copies of all reports and records relating to such examination or treatment, including X rays and insurance information. A health care practitioner may furnish the requested reports and records in paper form or, upon request, in an electronic format. A health care practitioner who maintains an electronic health record system shall furnish the requested reports and records in the manner chosen by the requester, including, but not limited to, an electronic format, submission through a patient's electronic personal health record, or access through a web-based patient portal if the practitioner maintains a patient portal. For purposes of this section,

900268

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
04/02/2025	.	
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The Committee on Health Policy (Grall) recommended the following:

Senate Amendment (with title amendment)

Delete lines 463 - 474.

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

And the title is amended as follows:

Delete line 42

and insert:

amending ss. 316.1932, 316.1933, 395.4025,

894726

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
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The Committee on Health Policy (Grall) recommended the following:

Senate Substitute for Amendment (900268) (with title amendment)

Delete lines 463 - 511
and insert:

Section 10. Subsection (1) of section 429.294, Florida Statutes, is amended to read:

429.294 Availability of facility records for investigation of resident’s rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident’s

894726

records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility in accordance with s. 408.833 ~~s. 400.145~~, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

Section 11. Subsection (4) of section 440.185, Florida Statutes, is amended to read:

440.185 Notice of injury or death; reports; penalties for violations.—

(4) Additional reports with respect to such injury and of the condition of such employee, including copies of medical reports, funeral expenses, and wage statements, shall be filed by the employer or carrier to the department at such times and in such manner as the department may prescribe by rule. In carrying out its responsibilities under this chapter, the department or agency may by rule provide for the obtaining of any medical records relating to medical treatment provided pursuant to this chapter, notwithstanding the provisions of ss. 90.503 and 395.3025(2) ~~395.3025(4)~~.

Section 12. Subsection (3) of section 456.47, Florida Statutes, is amended to read:

456.47 Use of telehealth to provide services.—

(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standard as used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing such

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services, are confidential pursuant to ss. 395.3025(2) and 456.057 ~~ss. 395.3025(4) and 456.057~~.

Section 13. This act shall take effect January 1, 2026.

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

And the title is amended as follows:

Delete line 42

and insert:

amending ss. 316.1932, 316.1933, 395.4025,

By Senator Grall

29-01058A-25 20251606__

A bill to be entitled

An act relating to patient access to records; amending s. 394.4615, F.S.; requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request for such records; requiring that certain service providers furnish such records in the manner chosen by the requester; amending s. 395.3025, F.S.; removing provisions requiring a licensed facility to furnish patient records only after discharge to conform to changes made by the act; revising provisions relating to the appropriate disclosure of patient records without consent; amending s. 397.501, F.S.; requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request from an individual or the individual's legal representative; requiring that certain service providers furnish such records in the manner chosen by the requester; amending s. 400.145, F.S.; revising the timeframe within which a nursing home facility must provide access to and copies of resident records after receiving a request for such records; creating s. 408.833, F.S.; defining the term "legal representative"; requiring a provider to furnish and provide access to records within a specified timeframe after receiving a request from a client or the client's legal representative; requiring that certain providers furnish such records in the manner chosen by the requester; authorizing a provider to impose

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reasonable terms necessary to preserve such records; providing exceptions; amending s. 456.057, F.S.; requiring certain licensed health care practitioners to furnish and provide access to copies of reports and records within a specified timeframe after receiving a request from a patient or the patient's legal representative; requiring that certain licensed health care practitioners furnish such reports and records in the manner chosen by the requester; defining the term "legal representative"; authorizing such licensed health care practitioners to impose reasonable terms necessary to preserve such reports and records; amending ss. 316.1932, 316.1933, 395.4025, 400.0234, 429.294, 440.185, and 456.47, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsections (3) through (12) of section 394.4615, Florida Statutes, are renumbered as subsections (4) through (13), respectively, and a new subsection (3) is added to that section, to read:

394.4615 Clinical records; confidentiality.—

(3) Within 14 working days after receiving a request made in accordance with paragraphs (2)(a)-(c), a service provider must furnish clinical records in its possession. A service provider may furnish the requested records in paper form or, upon request, in an electronic format. A service provider who maintains an electronic health record system shall furnish the

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requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

Section 2. Subsections (4) through (11) of section 395.3025, Florida Statutes, are renumbered as subsections (2) through (9), respectively, and subsections (1), (2), and (3), paragraph (e) of present subsection (4), paragraph (a) of present subsection (7), and present subsection (8) of that section, are amended to read:

395.3025 Patient and personnel records; copy costs ~~copies~~; examination.—

(1) ~~Any licensed facility shall, upon written request, and only after discharge of the patient, furnish, in a timely manner, without delays for legal review, to any person admitted therein for care and treatment or treated thereat, or to any such person's guardian, curator, or personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor, or to anyone designated by such person in writing, a true and correct copy of all patient records, including X rays, and insurance information concerning such person, which records are in the possession of the licensed facility, provided the person requesting such records agrees to pay a charge.~~ The exclusive charge for copies of patient records may include sales tax and actual postage, and, except for nonpaper records that are subject to a charge not to exceed $2, may not exceed $1 per page. A fee of up to $1 may be charged for each year of records requested. These charges shall apply to all records furnished, whether directly from the facility or from a

copy service providing these services on behalf of the facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search. ~~The licensed facility shall further allow any such person to examine the original records in its possession, or microforms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to assure that the records will not be damaged, destroyed, or altered.~~

~~(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.~~

~~(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.~~

(2)~~(4)~~ Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:

(e) The Department of Health ~~agency~~ upon subpoena issued pursuant to s. 456.071, but the records obtained thereby must be used solely for the purpose of the department ~~agency~~ and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the department ~~agency~~ requests copies of the records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records must be sealed and must not

be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor may they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department ~~agency~~ or the appropriate regulatory board. However, the department ~~agency~~ must make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause.

(5)(a) ~~(7)(a)~~ If the content of any record of patient treatment is provided under this section, the recipient~~, if other than the patient or the patient's representative,~~ may use such information only for the purpose provided and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose. The content of such patient treatment record is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(6) ~~(8)~~ Patient records at hospitals and ambulatory surgical centers are exempt from disclosure under s. 119.07(1), except as provided by subsections (2) and (3) ~~(1)-(5)~~.

Section 3. Paragraphs (a) through (j) of subsection (7) of section 397.501, Florida Statutes, are redesignated as paragraphs (c) through (l), respectively, and new paragraphs (a) and (b) are added to that subsection, to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are

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guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(7) RIGHT TO ACCESS AND CONFIDENTIALITY OF INDIVIDUAL RECORDS.—

(a) Within 14 working days after receiving a written request from an individual or an individual's legal representative, a service provider shall furnish a true and correct copy of all records in the possession of the service provider. The service provider may furnish the requested records in paper form or, upon request, in an electronic format. A service provider that maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record. For purposes of this section, the term "legal representative" has the same meaning as provided in s. 408.833(1).

(b) Within 10 working days after receiving such a request from an individual or an individual's legal representative, a service provider shall provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. The service provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

Section 4. Subsection (1) of section 400.145, Florida Statutes, is amended to read:

400.145 Copies of records of care and treatment of resident.—

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(1) Upon receipt of a written request that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this section, a nursing home facility shall furnish to a competent resident, or to a representative of that resident who is authorized to make requests for the resident's records under HIPAA or subsection (2), copies of the resident's paper and electronic records that are in possession of the facility. Such records must include any medical records and records concerning the care and treatment of the resident performed by the facility, except for progress notes and consultation report sections of a psychiatric nature. The facility shall provide a resident with access to the requested records within 24 hours, excluding weekends and holidays, and provide copies of the requested records within 2 ~~14~~ working days after receipt of a request relating to a current resident or within 30 working days after receipt of a request relating to a former resident.

Section 5. Section 408.833, Florida Statutes, is created to read:

408.833 Client access to medical records.—

(1) For purposes of this section, the term "legal representative" means an attorney who has been designated by a client to receive copies of the client's medical, care and treatment, or interdisciplinary records; a legally recognized guardian of the client; a court-appointed representative of the client; or a person designated by the client or by a court of competent jurisdiction to receive copies of the client's medical, care and treatment, or interdisciplinary records.

(2) Within 14 working days after receiving a written

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

request from a client or client's legal representative, a provider shall furnish a true and correct copy of all records, including medical, care and treatment, and interdisciplinary records, as applicable, in the possession of the provider. A provider may furnish the requested records in paper form or, upon request, in an electronic format. A provider that maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

(3) Within 10 working days after receiving a request from a client or a client's legal representative, a provider shall provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. A provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

(4) This section does not apply to:

(a) Records maintained at a licensed facility, as defined in s. 395.002, the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by s. 394.4615;

(b) Records of substance abuse impaired persons which are governed by s. 397.501; or

(c) Records of a resident of a nursing home facility.

Section 6. Subsection (6) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(6)(a) Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any patient ~~person~~ shall, upon request of such patient ~~person~~ or the patient's ~~person's~~ legal representative, furnish, within 14 working days after such request ~~in a timely manner, without delays for legal review~~, copies of all reports and records relating to such examination or treatment, including X rays and insurance information. A health care practitioner may furnish the requested reports and records in paper form or, upon request, in an electronic format. A health care practitioner who maintains an electronic health record system shall furnish the requested reports and records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record. For purposes of this section, the term "legal representative" means a patient's attorney who has been designated by the patient to receive copies of the patient's medical records, a legally recognized guardian of the patient, a court-appointed representative of the patient, or any other person designated by the patient or by a court of competent jurisdiction to receive copies of the patient's medical records.

(b) Within 10 working days after receiving a written request by a patient or a patient's legal representative, a healthcare practitioner must provide access to examine the original reports and records, or microforms or other suitable

reproductions of the reports and records in the healthcare practitioner's possession. The healthcare practitioner may impose any reasonable terms necessary to ensure that the reports and records will not be damaged, destroyed, or altered.

(c) ~~However,~~ When a patient's psychiatric, chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies may ~~shall~~ not be conditioned upon payment of a fee for services rendered.

Section 7. Paragraph (f) of subsection (1) of section 316.1932, Florida Statutes, is amended to read:

316.1932 Tests for alcohol, chemical substances, or controlled substances; implied consent; refusal.—

(1)

(f)1. The tests determining the weight of alcohol in the defendant's blood or breath shall be administered at the request of a law enforcement officer substantially in accordance with rules of the Department of Law Enforcement. Such rules must specify precisely the test or tests that are approved by the Department of Law Enforcement for reliability of result and ease of administration, and must provide an approved method of administration which must be followed in all such tests given under this section. However, the failure of a law enforcement officer to request the withdrawal of blood does not affect the admissibility of a test of blood withdrawn for medical purposes.

2.a. Only a physician, certified paramedic, registered nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, acting at the request of a law enforcement officer, may withdraw blood for the purpose of determining its alcoholic content or the presence of chemical substances or controlled substances therein. However, the failure of a law enforcement officer to request the withdrawal of blood does not affect the admissibility of a test of blood withdrawn for medical purposes.

b. Notwithstanding any provision of law pertaining to the confidentiality of hospital records or other medical records, if a health care provider, who is providing medical care in a health care facility to a person injured in a motor vehicle crash, becomes aware, as a result of any blood test performed in the course of that medical treatment, that the person's blood-alcohol level meets or exceeds the blood-alcohol level specified in s. 316.193(1)(b), the health care provider may notify any law enforcement officer or law enforcement agency. Any such notice must be given within a reasonable time after the health care provider receives the test result. Any such notice shall be used only for the purpose of providing the law enforcement officer with reasonable cause to request the withdrawal of a blood sample pursuant to this section.

c. The notice shall consist only of the name of the person being treated, the name of the person who drew the blood, the blood-alcohol level indicated by the test, and the date and time of the administration of the test.

d. Nothing contained in s. 395.3025(2) ~~s. 395.3025(4)~~, s.

456.057, or any applicable practice act affects the authority to provide notice under this section, and the health care provider is not considered to have breached any duty owed to the person under s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act by providing notice or failing to provide notice. It shall not be a breach of any ethical, moral, or legal duty for a health care provider to provide notice or fail to provide notice.

e. A civil, criminal, or administrative action may not be brought against any person or health care provider participating in good faith in the provision of notice or failure to provide notice as provided in this section. Any person or health care provider participating in the provision of notice or failure to provide notice as provided in this section shall be immune from any civil or criminal liability and from any professional disciplinary action with respect to the provision of notice or failure to provide notice under this section. Any such participant has the same immunity with respect to participating in any judicial proceedings resulting from the notice or failure to provide notice.

3. The person tested may, at his or her own expense, have a physician, registered nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, or other person of his or her own choosing administer an independent test in addition to the test administered at the direction of the law enforcement officer for the purpose of determining the amount of alcohol in the person’s blood or breath or the presence of chemical substances or controlled substances at the time

alleged, as shown by chemical analysis of his or her blood or urine, or by chemical or physical test of his or her breath. The failure or inability to obtain an independent test by a person does not preclude the admissibility in evidence of the test taken at the direction of the law enforcement officer. The law enforcement officer shall not interfere with the person's opportunity to obtain the independent test and shall provide the person with timely telephone access to secure the test, but the burden is on the person to arrange and secure the test at the person's own expense.

4. Upon the request of the person tested, full information concerning the results of the test taken at the direction of the law enforcement officer shall be made available to the person or his or her attorney. Full information is limited to the following:

a. The type of test administered and the procedures followed.

b. The time of the collection of the blood or breath sample analyzed.

c. The numerical results of the test indicating the alcohol content of the blood and breath.

d. The type and status of any permit issued by the Department of Law Enforcement which was held by the person who performed the test.

e. If the test was administered by means of a breath testing instrument, the date of performance of the most recent required inspection of such instrument.

Full information does not include manuals, schematics, or

software of the instrument used to test the person or any other material that is not in the actual possession of the state. Additionally, full information does not include information in the possession of the manufacturer of the test instrument.

5. A hospital, clinical laboratory, medical clinic, or similar medical institution or physician, certified paramedic, registered nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, or other person assisting a law enforcement officer does not incur any civil or criminal liability as a result of the withdrawal or analysis of a blood or urine specimen, or the chemical or physical test of a person's breath pursuant to accepted medical standards when requested by a law enforcement officer, regardless of whether or not the subject resisted administration of the test.

Section 8. Paragraph (a) of subsection (2) of section 316.1933, Florida Statutes, is amended to read:

316.1933 Blood test for impairment or intoxication in cases of death or serious bodily injury; right to use reasonable force.—

(2)(a) Only a physician, certified paramedic, registered nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, acting at the request of a law enforcement officer, may withdraw blood for the purpose of determining the alcoholic content thereof or the presence of chemical substances or controlled substances therein. However, the failure of a law enforcement officer to

request the withdrawal of blood shall not affect the admissibility of a test of blood withdrawn for medical purposes.

1. Notwithstanding any provision of law pertaining to the confidentiality of hospital records or other medical records, if a health care provider, who is providing medical care in a health care facility to a person injured in a motor vehicle crash, becomes aware, as a result of any blood test performed in the course of that medical treatment, that the person's blood-alcohol level meets or exceeds the blood-alcohol level specified in s. 316.193(1)(b), the health care provider may notify any law enforcement officer or law enforcement agency. Any such notice must be given within a reasonable time after the health care provider receives the test result. Any such notice shall be used only for the purpose of providing the law enforcement officer with reasonable cause to request the withdrawal of a blood sample pursuant to this section.

2. The notice shall consist only of the name of the person being treated, the name of the person who drew the blood, the blood-alcohol level indicated by the test, and the date and time of the administration of the test.

3. Nothing contained in s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act affects the authority to provide notice under this section, and the health care provider is not considered to have breached any duty owed to the person under s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act by providing notice or failing to provide notice. It shall not be a breach of any ethical, moral, or legal duty for a health care provider to provide notice or fail to provide notice.

4. A civil, criminal, or administrative action may not be brought against any person or health care provider participating in good faith in the provision of notice or failure to provide notice as provided in this section. Any person or health care provider participating in the provision of notice or failure to provide notice as provided in this section shall be immune from any civil or criminal liability and from any professional disciplinary action with respect to the provision of notice or failure to provide notice under this section. Any such participant has the same immunity with respect to participating in any judicial proceedings resulting from the notice or failure to provide notice.

Section 9. Subsection (13) of section 395.4025, Florida Statutes, is amended to read:

395.4025 Trauma centers; selection; quality assurance; records.—

(13) Patient care, transport, or treatment records or reports, or patient care quality assurance proceedings, records, or reports obtained or made pursuant to this section, s. 395.3025(2)(f) ~~s. 395.3025(4)(f)~~, s. 395.401, s. 395.4015, s. 395.402, s. 395.403, s. 395.404, s. 395.4045, s. 395.405, s. 395.50, or s. 395.51 must be held confidential by the department or its agent and are exempt from the provisions of s. 119.07(1). Patient care quality assurance proceedings, records, or reports obtained or made pursuant to these sections are not subject to discovery or introduction into evidence in any civil or administrative action.

Section 10. Subsection (1) of section 400.0234, Florida Statutes, is amended to read:

400.0234 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility in accordance with s. 408.833 ~~s. 400.145~~ shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

Section 11. Subsection (1) of section 429.294, Florida Statutes, is amended to read:

429.294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility in accordance with s. 408.833 ~~s. 400.145~~, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

Section 12. Subsection (4) of section 440.185, Florida Statutes, is amended to read:

440.185 Notice of injury or death; reports; penalties for violations.—

(4) Additional reports with respect to such injury and of the condition of such employee, including copies of medical reports, funeral expenses, and wage statements, shall be filed

by the employer or carrier to the department at such times and in such manner as the department may prescribe by rule. In carrying out its responsibilities under this chapter, the department or agency may by rule provide for the obtaining of any medical records relating to medical treatment provided pursuant to this chapter, notwithstanding the provisions of ss. 90.503 and 395.3025(2) ~~395.3025(4)~~.

Section 13. Subsection (3) of section 456.47, Florida Statutes, is amended to read:

456.47 Use of telehealth to provide services.—

(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standard as used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing such services, are confidential pursuant to ss. 395.3025(2) and 456.057 ~~ss. 395.3025(4) and 456.057~~.

Section 14. This act shall take effect July 1, 2025.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 6, 2025

I respectfully request that **Senate Bill #1606**, relating to Patient Access to Records, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Erin K. Grall

Senator Erin Grall
Florida Senate, District 29

File signed original with committee office

S-020 (03/2004)

Tab 1

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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1 Apr 25
Meeting Date

Health Policy
Committee

1606
Bill Number or Topic

Amendment Barcode (if applicable)

Name Cynthia Henderson

Phone 8505590855

Address 300 W Pensacola
Street

Email cyhenderson@me.com

Tall FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
AHIOS

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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Tab 1

4/1/25
Meeting Date

Health Policy
Committee

1606 Medical Records
Bill Number or Topic

Amendment Barcode (if applicable)

Name Bill Cotterall

Phone

Address 218 S. Monroe ST
Street

Email

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Florida Justice Association

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

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

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The Florida Senate

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Tab 1

4/1/25
Meeting Date

Health Policy
Committee

1606
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jason Fraxedas

Phone 407-455-1060

Address 1201 Sharon Place
Street

Email jrfraxedas@gmail.com

Winter Park FL 32789
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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The Florida Senate

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04/01/2025
Meeting Date

Health Policy
Committee

SB 1606
Bill Number or Topic

Amendment Barcode (if applicable)

Name Edda Fernandez

Phone 954-850-7262

Address 215 Monroe Street 603
Street

Email ifernandez@aarp.org

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP

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

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

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S-001 (08/10/2021)

A black and white copy of this document is not official

35

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Shevaun L. Harris

is duly appointed

Secretary,
Agency for Health Care Administration

for a term beginning on the Twenty-Fifth day of February, A.D., 2025, to serve at the pleasure of the Governor and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fifth day of March, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.
"State of Florida" appears in small letters across the face of this 8½ x 11" document.
The original document has a reflective line mark in paper. Hold at an angle to view when checking.

RON DESANTIS
GOVERNOR

RECEIVED
2025 FEB 28 AM 10:05
DIVISION OF ELECTIONS
TALLAHASSEE, FL

February 25, 2025

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 20.42, Florida Statutes:

Ms. Shevaun Harris

as Secretary of the Agency for Health Care Administration, filling a vacant seat previously occupied by Jason Weida, subject to confirmation by the Senate. This appointment is effective February 25, 2025, for a term ending at the pleasure of the Governor.

Sincerely,

Ron DeSantis
Governor

RD/ch

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

HAND DELIVERED

RECEIVED

2025 FEB 28 PM 4:35

DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of Leon

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Secretary, Florida Agency for Health Care Administration

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[NOTE: If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

Shevaun

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of X *physical presence*

Or ___ *online notarization this* 26th *day of* February, *20* 25.

Bridget A. Royster

Signature of Officer Administering Oath or of Notary Public

BRIDGET A. ROYSTER
MY COMMISSION # HH 208000
EXPIRES: January 16, 2026
Bonded Thru Notary Public Underwriters

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☑ *or Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☑ Office ☐

Street or Post Office Box

City, State, Zip Code

Shevaun L. Harris

Print Name

Shevaun

Signature

The Florida Senate

Committee Notice Of Hearing

IN THE FLORIDA SENATE
TALLAHASSEE, FLORIDA

IN RE: Executive Appointment of

Shevaun Harris

Secretary of Health Care Administration

NOTICE OF HEARING

TO: Secretary Shevaun Harris

YOU ARE HEREBY NOTIFIED that the Committee on Health Policy of the Florida Senate will conduct a hearing on your executive appointment on Tuesday, April 1, 2025, in the Pat Thomas Committee Room, 412 Knott Building, commencing at 1:30 p.m., pursuant to Rule 12.7(1) of the Rules of the Florida Senate.

Please be present at the time of the hearing.
DATED this the 21st day of March, 2025

Committee on Health Policy

Senator Colleen Burton
As Chair and by authority of the committee

cc: Members, Committee on Health Policy
Office of the Sergeant at Arms

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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4/1/2025
Meeting Date

Health Policy
Committee

Tab 2 - Confirmation Hearing
Bill Number or Topic

Amendment Barcode (if applicable)

Name Mary C. Mayhew

Phone 8502229800

Email Marym@fha.org

Address 306 E College Ave
Street

Tallahassee FL 32312
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Hospital Association

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

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

S-001 (08/10/2021)

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The Florida Senate

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4-1-2025
Meeting Date

Senate Health Policy
Committee

Confirmation of Secretary of AHCA - Harris, Shevaun
Bill Number or Topic

Amendment Barcode (if applicable)

Name Melanie Brown Woofter

Phone 850-224-6048

Email melanie@floridabha.org

Address 316 East Park Ave
Street

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Council for Behavioral Healthcare

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

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

S-001 (08/10/2021

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The Florida Senate

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4-1-25
Meeting Date

Health Policy
Committee

Confirmation of Sheraun Harris
Bill Number or Topic

Amendment Barcode (if applicable)

Name Justin Senior

Phone 850-201-2096

Email justin@snhaf.net

Address 125 S. Gadsden St.
Street

Tallahassee FL 32301
City State Zip

Enthusiastic support!

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Safety Net Hospital Alliance

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

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

S-001 (08/10/2021)

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The Florida Senate

APPEARANCE RECORD

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April 1, 2025
Meeting Date

Health Policy
Committee

Sec of AHCA-Shevaun Harris Confirmation
Bill Number or Topic

Amendment Barcode (if applicable)

Name Steve Bahmer

Phone (850) 671-3700

Email sbahmer@leadingagesoutheast.org

Address 1812 Riggins Road
Street

Tallahassee FL 32308
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

LeadingAge Southeast, President/CEO

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

S-001 (08/10/202

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APPEARANCE RECORD

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4-1-2025
Meeting Date

Health Policy
Committee

Shevaun Harris @ AHCA
Bill Number or Topic

Amendment Barcode (if applicable)

Name Margaret J. Hooper

Phone 850-294-0052

Address 124 Marriott Drive #203
Street

Tallahassee FL 32311
City State Zip

Email MargaretD@FDDC.org

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
FL. Dev. Disabilities Council

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

4/1/25
Meeting Date

Health Policy
Committee

AHCA Confirm...
Sec. S. Harris
Bill Number or Topic

Amendment Barcode (if applicable)

Name Taylor Cheeseman

Phone 601-454-3787

Email tcheeseman@childrenshomenetwork.org

Address 350 Cypress Creek Cir
Street

Oldsmar FL 34677
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

S-001 (08/10/202

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

The Florida Senate

APPEARANCE RECORD

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

Tab 4

James Matthew Knight, MD

Bill Number or Topic

Amendment Barcode (if applicable)

4/1/25

Meeting Date

Health Policy

Committee

Name Chris Nuland

Phone 904-233-3051

Email nulandlaw@aol.com

Address 4427 Herschel St

Street

Jacksonville, FL 32210

City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

Florida Academy of Dermatology

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

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

S-001 (08/10/2021)

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

The Florida Senate

APPEARANCE RECORD

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

4/1/25
Meeting Date

HEALTH POLICY
Committee

AHCA CONFIRMATION
Sec. S. Harris
Bill Number or Topic

Amendment Barcode (if applicable)

Name VICTORIA ZEPP

Phone 833 618 8180

Email VICTORIA@TEAM180.COM

Address 310 W. College Ave
Street

TLH FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: One Hope United

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

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

S-001 (08/10/2021)

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

The Florida Senate

APPEARANCE RECORD

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

4/1/25
Meeting Date

Health Policy
Committee

Sec. S. Harris
Bill Number or Topic

Amendment Barcode (if applicable)

Name VICTORIA ZEPP

Phone 833 618 8180

Email VICTORIA@TEAM180.COM

Address 310 W. College Ave
Street

TLH FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Family Support Services

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

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

S-001 (08/10/202

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

The Florida Senate

APPEARANCE RECORD

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

4-1-25
Meeting Date

Committee

Secretary Harris
Bill Number or Topic

Conf
Amendment Barcode (if applicable)

Name EMMETT REED

Phone 850-251-1057

Email EReed@FHCA.org

Address 307 W Park
Street

Tallahassee FL 32312
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: FLORIDA HEALTH CARE ASSOCIATION

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

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

S-001 (08/10/2021

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

The Florida Senate

APPEARANCE RECORD

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

4-1-25
Meeting Date

Health Policy
Committee

AHCA Harris
Bill Number or Topic

Amendment Barcode (if applicable)

Name Tyler Summit

Phone 850-228-4810

Address 3111 E Tenn St.
Street

Email tsummit@floridaarf.org

Tallahassee FL 32308
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida ARF

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

April 1, 2025
Meeting Date

Confirmation Hearing
Shevaun Harris
Bill Number or Topic

Amendment Barcode (if applicable)

Committee

Name Dr. Melissa Olivé, Executive Director Phone (512) 426-1924

Address P.O. Box 10448 Email Molivé@fabaworld.org
Street

Tallahassee, FL 32302
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

Florida Association for Behavior Analysis

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

S-001 (08/10/2021)

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

THE FLORIDA SENATE

COMMITTEE WITNESS OATH

CHAIR:

Please raise your right hand and be sworn in as a witness.

Do you swear or affirm that the evidence you are about to give will be the truth, the whole truth, and nothing but the truth?

WITNESS'S NAME: Shevaun L. Harris

ANSWER: Yes, I do.

Pursuant to §90.605(1), *Florida Statutes*: "The witness's answer shall be noted in the record."

COMMITTEE NAME: Senate Health Policy Committee

DATE: 04/01/2025

Attach in Session Organizer

S-002 (02/11/2020)

A black and white copy of this document is not official

170

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Howard Wesley Baum, III

is duly appointed a member of the

Board of Chiropractic Medicine

for a term beginning on the Nineteenth day of July, A.D., 2024, until the Thirty-First day of October, A.D., 2025 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Eighteenth day of February, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.
"State of Florida" appears in small letters across the face of this 8½ x 11" document.
The original document has a reflective line mark in paper. Hold at an angle to view when checking.

RON DESANTIS
GOVERNOR

RECEIVED
DEPARTMENT OF STATE
2024 JUL 23 AM 10:48
DIVISION OF ELECTIONS
TALLAHASSEE, FL

July 19, 2024

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 460.404, Florida Statutes:

Mr. Howard Baum
3013 Colonial Ridge Drive
Brandon, Florida 33511

as a member of the Board of Chiropractic Medicine, filling a vacant seat previously occupied by Luis Fuste, subject to confirmation by the Senate. This appointment is effective July 19, 2024, for a term ending October 31, 2025.

Sincerely,

Ron DeSantis
Governor

RD/es

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of Hillsborough

I do solemnly swear (or affirm) that I will support. protect. and defend the Constitution and Government of the United States and of the State of Florida: that I am duly qualified to hold office under the Constitution of the State. and that I will well and faithfully perform the duties of

Cousumer Board Member to Florida Board of Chiropractic Medicine

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter. so help me God.

[NOTE: If you affirm. you may omit the words "so help me God." *See* § 92.52. Fla. Stat.]

Howard Wesley Baum III

Signature

(Affix Seal Below)

GERALD A TORRE
Notary Public - State of Florida
Commission # HH 508985
My Comm. Expires Jul 22, 2028
Bonded through National Notary Assn.

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 29 *day of* January, 20 25.

Signature of Officer Administering Oath or of Notary Public

Gerald A Torre

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☑ *or Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☒ Office ☐

3013 Colonial Ridge Drive

Street or Post Office Box

Howard Wesley Baum III

Print Name

Brandon, FL 33511

City. State. Zip Code

Howard Wesley Baum III

Signature

A black and white copy of this document is not official

170

STATE OF FLORIDA
DEPARTMENT OF STATE
Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Gretchen Saunders

is duly appointed a member of the

Board of Chiropractic Medicine

for a term beginning on the Fourteenth day of February, A.D., 2025, until the Thirty-First day of October, A.D., 2027 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fifth day of March, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

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"State of Florida" appears in small letters across the face of this 8½ x 11" document.
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RON DESANTIS
GOVERNOR

RECEIVED
2025 FEB 25 AM 10:08
DIVISION OF ELECTIONS
TALLAHASSEE, FL

February 14, 2025

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 460.404, Florida Statutes:

Ms. Gretchen Saunders
11711 Pilot Country Drive
Spring Hill, Florida 34510

as a member of the Board of Chiropractic Medicine, subject to confirmation by the Senate. This appointment is effective February 14, 2025, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/js

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

RECEIVED

2025 MAR -4 PM 3:14

DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of Pasco

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Florida Board of Chiropractic Medicine

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[**NOTE:** If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

Gretchen Saunders

Signature

(Affix Seal Below)

STEPHANIE GILMORE
NOTARY
My Comm. Expires
May 10, 2027
No. HH 389393
PUBLIC
STATE OF FLORIDA

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 28 *day of* Feb, 2025

Stephanie Gilmore

Signature of Officer Administering Oath or of Notary Public

Stephanie Gilmore

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☐ *or Produced Identification* ☑

Type of Identification Produced Fldr lic

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☒ Office ☐

11711 Pilot Country DR.

Street or Post Office Box

Spring Hill, FL 34610

City, State, Zip Code

Gretchen Saunders

Print Name

Gretchen Saunders

Signature

A black and white copy of this document is not official

170

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Anthony B. Oliverio

is duly appointed a member of the

Board of Chiropractic Medicine

for a term beginning on the Fourteenth day of February, A.D., 2025, until the Thirty-First day of October, A.D., 2028 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twentieth day of March, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.
"State of Florida" appears in small letters across the face of this 8½ x 11" document.
The original document has a reflective line mark in paper. Hold at an angle to view when checking.

RON DESANTIS
GOVERNOR

RECEIVED
2025 FEB 25 AM 10:08
DIVISION OF ELECTIONS
TALLAHASSEE, FL

February 14, 2025

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 460.404, Florida Statutes:

Dr. Anthony Oliverio
1460 Northwest 3rd Street
Crystal River, Florida 34428

as a member of the Board of Chiropractic Medicine, subject to confirmation by the Senate. This appointment is effective February 14, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/js

RECEIVED
DEPARTMENT OF STATE
2025 MAR 14 PM 1:04
DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of Citrus

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Florida Board of Chiropractic Medicine

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[**NOTE:** If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

A B. Oliverio DC

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 13th *day of* March, 2025.

MISTY ATKINSON
Notary Public, State of Florida
My Comm. Expires 06/24/20
Commission No. HH 56[illegible]

Misty Atkinson

Signature of Officer Administering Oath or of Notary Public

Misty Atkinson

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☐ *or Produced Identification* ☑

Type of Identification Produced FL DL

MISTY ATKINSON
Notary Public, State of Florida
My Comm. Expires 06/24/2028
Commission No. HH 564672

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☐ Office ☑

912 NE 5th Street
Street or Post Office Box

Crystal River, FL 34429
City, State, Zip Code

Anthony B. Oliverio DC
Print Name

A B Oliverio DC
Signature

A black and white copy of this document is not official

170

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Jason Comerford

is duly appointed a member of the

Board of Chiropractic Medicine

for a term beginning on the Fourteenth day of February, A.D., 2025, until the Thirty-First day of October, A.D., 2028 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Seventh day of March, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.
"State of Florida" appears in small letters across the face of this 8½ x 11" document.
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RON DESANTIS
GOVERNOR

RECEIVED
2025 FEB 25 AM 10:08
DIVISION OF ELECTIONS
TALLAHASSEE, FL

February 14, 2025

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 460.404, Florida Statutes:

Dr. Jason Comerford
285 Wishing Well Circle Southwest
Palm Bay, Florida 32908

as a member of the Board of Chiropractic Medicine, subject to confirmation by the Senate. This appointment is effective February 14, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/js

RECEIVED
DEPARTMENT OF STATE
2025 MAR -5 AM 10:28
DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of BREVARD

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

FLORIDA BOARD OF CHIROPRACTIC MEDICINE

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[**NOTE:** If you affirm, you may omit ~~the words "so help me God."~~ *See* § 92.52, Fla. Stat.]

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 21 *day of* February, 20 25.

NOTARY PUBLIC STATE OF FLORIDA
KIM OSTRANDER
Commission # HH 590998
Expires September 20, 2028

Signature of Officer Administering Oath or of Notary Public

Kim Ostrander

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☑ *or Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☒ Office ☐

285 WISHING WELL CIR SW
Street or Post Office Box

PALM BAY, FL 32908
City, State, Zip Code

DR JASON COMERFORD
Print Name

Signature

A black and white copy of this document is not official

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Scot N. Ackerman

is duly appointed a member of the

Board of Medicine

for a term beginning on the Sixteenth day of August, A.D., 2024, until the Thirty-First day of October, A.D., 2026 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fourth day of September, A.D., 2024.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.
"State of Florida" appears in small letters across the face of this 8½ x 11" document.
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RON DESANTIS
GOVERNOR

RECEIVED
DEPARTMENT OF STATE
2024 AUG 28 AM 9:58
DIVISION OF ELECTIONS
TALLAHASSEE, FL

August 16, 2024

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 458.307, Florida Statutes:

Dr. Scot Ackerman

as a member of the Board of Medicine, subject to confirmation by the Senate. This appointment is effective August 16, 2024, for a term ending October 31, 2026.

Sincerely,

Ron DeSantis
Governor

RD/es

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

RECEIVED
DEPARTMENT OF STATE
2024 AUG 23 AM 8:24
DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of DUVAL

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[NOTE: If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.**]**

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 20th *day of* August, 2024.

Notary Public State of Florida
Amy Mousa
My Commission
HH 169625
Exp. 8/25/2025

Amy Mousa

Signature of Officer Administering Oath or of Notary Public

Amy Mousa

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☒ *or Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☑ Office ☐

_____ Scot N. Ackerman

Street or Post Office Box **Print Name**

_____ _____ _____

City, State, Zip Code **Signature**

A black and white copy of this document is not official

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Hector Vila, Jr.

is duly appointed a member of the

Board of Medicine

for a term beginning on the Sixteenth day of August, A.D., 2024, until the Thirty-First day of October, A.D., 2026 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Second day of November, A.D., 2024.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.
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RON DESANTIS
GOVERNOR

RECEIVED
DEPARTMENT OF STATE
2024 AUG 28 AM 9:57
DIVISION OF ELECTIONS
TALLAHASSEE, FL

August 16, 2024

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 458.307, Florida Statutes:

Dr. Hector Vila
4416 West Azeele Street
Tampa, Florida 33609

as a member of the Board of Medicine, subject to confirmation by the Senate. This appointment is effective August 16, 2024, for a term ending October 31, 2026.

Sincerely,

Ron DeSantis
Governor

RD/es

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

32962

RECEIVED
DEPARTMENT OF STATE
2024 OCT -4 AM 8:55
DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of Hillsborough

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[***NOTE:*** *If you affirm, you may omit the words "so help me God." See § 92.52, Fla. Stat.*]

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 21 *day of* September, 2024.

Notary Public State of Florida
Dina Alvarez Perez
My Commission
HH 221519
Exp. 2/19/2026

Signature of Officer Administering Oath or of Notary Public

Dina Alvarez Perez

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☑ *or Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ■ Office ☐

4416 W Azeele St

Street or Post Office Box

Tampa, Fl 33609

City, State, Zip Code

Hector Vila Jr MD

Print Name

Signature

A black and white copy of this document is not official

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

James Matthew Knight

is duly appointed a member of the

Board of Medicine

for a term beginning on the Sixteenth day of August, A.D., 2024, until the Thirty-First day of October, A.D., 2027 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fourth day of September, A.D., 2024.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.

"State of Florida" appears in small letters across the face of this 8½ x 11" document.

The original document has a reflective line mark in paper. Hold at an angle to view when checking.

RON DESANTIS
GOVERNOR

RECEIVED
DEPARTMENT OF STATE
2024 AUG 28 AM 9:57
DIVISION OF ELECTIONS
TALLAHASSEE, FL

August 16, 2024

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 458.307, Florida Statutes:

Dr. J. "Matthew" Knight
2100 Via Tuscany
Winter Park, Florida 32789

as a member of the Board of Medicine, succeeding Eleonor Pimentel, subject to confirmation by the Senate. This appointment is effective August 16, 2024, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/es

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

RECEIVED
DEPARTMENT OF STATE
2024 AUG 29 AM 8:38
DIVISION OF ELECTIONS
TALLAHASSEE FL

STATE OF FLORIDA

County of Orange

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Board Member, Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[**NOTE:** If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of X *physical presence*

Or ___ *online notarization this* 21st *day of* August, 2024.

Notary Public State of Florida
Mary H Juravle
My Commission HH 400429
Expires 9/11/2027

Signature of Officer Administering Oath or of Notary Public

MARY H. JURAVLE

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☒ *or Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☑ Office ☐

2100 Via Tuscany

Street or Post Office Box

Winter Park, FL 32789

City, State, Zip Code

James Matthew Knight, M.D.

Print Name

Signature

DS-DE 56 (Rev. 09/23)

A black and white copy of this document is not official

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Steven Christie

is duly appointed a member of the

Board of Medicine

for a term beginning on the Sixteenth day of August, A.D., 2024, until the Thirty-First day of October, A.D., 2027 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Thirteenth day of September, A.D., 2024.

Secretary of State

DSDE 99 (3/03)

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"State of Florida" appears in small letters across the face of this 8½ x 11" document.

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RON DESANTIS
GOVERNOR

RECEIVED
DEPARTMENT OF STATE
2024 AUG 28 AM 9:57
DIVISION OF ELECTIONS
TALLAHASSEE, FL

August 16, 2024

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 458.307, Florida Statutes:

Dr. Steven Christie
524 Hampton Lane
Key Biscayne, Florida 33149

as a member of the Board of Medicine, succeeding Luz Marina Pages, subject to confirmation by the Senate. This appointment is effective August 16, 2024, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/cs

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

RECEIVED
DEPARTMENT OF STATE
2024 SEP -5 AM 8:24
DIVISION OF ELECTIONS
TALLAHASSEE, FL

STATE OF FLORIDA

County of MIAMI-DADE

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

FLORIDA BOARD OF MEDICINE BOARD MEMBER

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[**NOTE:** If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 26th *day of* August, 2024.

Signature of Officer Administering Oath or of Notary Public

ALDO E ZELAYA
Notary Public - State of Florida
Commission # HH 170640
My Comm. Expires Aug 29, 2025

Aldo E Zelaya

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☑ *or Produced Identification* ☐

Type of Identification Produced Florida Driver License.

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☒ Office ☐

524 Hampton Lane
Street or Post Office Box

Key Biscayne, FL 33149
City, State, Zip Code

Steven Christie
Print Name

Signature

A black and white copy of this document is not official

1665

STATE OF FLORIDA
DEPARTMENT OF STATE
Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Denise Burns-LeGros

is duly appointed a member of the

Board of Optometry

for a term beginning on the Twelfth day of April, A.D., 2024, until the Thirty-First day of October, A.D., 2027 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Fifth day of April, A.D., 2024.

Secretary of State

DSDE 99 (3/03)

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"State of Florida" appears in small letters across the face of this 8½ x 11" document.
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RON DESANTIS
GOVERNOR

RECEIVED
2024 APR 16 AM 9:36
DIVISION OF ELECTIONS
TALLAHASSEE, FL

April 12, 2024

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 463.003, Florida Statutes:

Dr. Denise Burns-LeGros
395 Newport Drive
Indialantic, Florida 32903

as a member of the Board of Optometry, subject to confirmation by the Senate. This appointment is effective April 12, 2024, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/ah

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

RECEIVED
DEPARTMENT OF STATE
2024 APR 23 AM 11:01
DEPARTMENT OF STATE
DIVISION OF ELECTIONS

STATE OF FLORIDA

County of Brevard

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Florida Board of Optometry

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[**NOTE:** If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

Signature Denise Burns-LeGros

(Affix Seal Below)

RITA E. JIMENEZ
Notary Public - State of Florida
Commission # HH 334596
My Comm. Expires Mar 14, 2027
Bonded through National Notary Assn.

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 22nd *day of* April, *20* 24

Rita E. Jimenez

Signature of Officer Administering Oath or of Notary Public

RITA E. JIMENEZ

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☑ *or Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☒ Office ☐

395 Newport Drive

Street or Post Office Box

Indialantic, Florida 32903

City, State, Zip Code

Denise Burns-LeGros

Print Name

Denise Burns-LeGros

Signature

A black and white copy of this document is not official

1665

STATE OF FLORIDA
DEPARTMENT OF STATE
Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Bryan Stam

is duly appointed a member of the

Board of Optometry

for a term beginning on the Twelfth day of April, A.D., 2024, until the Thirty-First day of October, A.D., 2027 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Nineteenth day of April, A.D., 2024.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.
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RON DESANTIS
GOVERNOR

RECEIVED
2024 APR 16 AM 9:36
DIVISION OF ELECTIONS
TALLAHASSEE, FL

April 12, 2024

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 463.003, Florida Statutes:

Dr. Bryan Stam
104 Nina Court
Ponte Vedra Beach, Florida 32082

as a member of the Board of Optometry, succeeding Stephen Kepley, subject to confirmation by the Senate. This appointment is effective April 12, 2024, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/ah

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

RECEIVED
DEPARTMENT OF STATE
2024 APR 19 AM 10:24
DEPARTMENT OF STATE
DIVISION OF ELECTIONS

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of Duval

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Board of Optometry
(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[**NOTE:** If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of X *physical presence*
Or ___ *online notarization this* 16th *day of* April, 2024.

JERI LYNN LEDBETTER
Notary Public - State of Florida
Commission # GG 974661
My Comm. Expires Jul 23, 2024
Bonded through National Notary Assn.

Signature of Officer Administering Oath or of Notary Public

Jeri Lynn Ledbetter
Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☒ *or Produced Identification* ☐

Type of Identification Produced ___

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☐ Office ☑

10915 Raymeadows Rd
Street or Post Office Box

Jacksonville, Fl 32256
City, State, Zip Code

Bryan Stam
Print Name

Signature

A black and white copy of this document is not official

1665

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Robert M. Easton, Jr.

is duly appointed a member of the

Board of Optometry

for a term beginning on the Twenty-Fourth day of January, A.D., 2025, until the Thirty-First day of October, A.D., 2028 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fifth day of March, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

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"State of Florida" appears in small letters across the face of this 8½ x 11" document.
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RON DESANTIS
GOVERNOR

RECEIVED
2025 JAN 30 PM 3:33
DIVISION OF ELECTIONS
TALLAHASSEE, FL

January 24, 2025

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 463.003, Florida Statutes:

Dr. Robert Easton
1587 Northeast 39th Street
Oakland Park, Florida 33334

as a member of the Board of Optometry, subject to confirmation by the Senate. This appointment is effective January 24, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/gc

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

RECEIVED
2025 FEB -3 AM 10:16
DIVISION OF ELECTIONS
TALLAHASSEE, FL

STATE OF FLORIDA

County of BROWARD

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

FLORIDA BOARD OF OPTOMETRY

(Full Name of Office – Abbreviations Not Accepted)

on which I am now about to enter, so help me God.

[NOTE: If you affirm, you may omit the ~~words~~ "so help me ~~God~~." *See* § 92.52, Fla. Stat.]

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of ✓ *physical presence*

Or ___ *online notarization this* 18 *day of* Feb., 2025.

Signature of Officer Administering Oath or of Notary Public

Print, Type, or Stamp Commissioned Name of Notary Public

Notary Public State of Florida
Rebecca A Norwood
My Commission HH 120103
Expires 07/23/2025

Personally Known ☑ *or Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☐ Office ☑

1580 E OAKLAND PARK BLVD

Street or Post Office Box

OAKLAND PARK, FL 33334

City, State, Zip Code

ROBERT M ERBTON JR OD FAAO

Print Name

Signature

A black and white copy of this document is not official!

1795

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Jason Cirolia

is duly appointed a member of the

Board of Physical Therapy Practice

for a term beginning on the Second day of February, A.D., 2024, until the Thirty-First day of October, A.D., 2026 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Second day of April, A.D., 2024.

Secretary of State

DSDE 99 (3/03)

If photocopied or chemically altered, the word "VOID" will appear.
"State of Florida" appears in small letters across the face of this 8½ x 11" document.
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RON DESANTIS
GOVERNOR

RECEIVED
2024 FEB -6 AM 9:45
DIVISION OF ELECTIONS
TALLAHASSEE, FL

February 2, 2024

Secretary Cord Byrd
Department of State
R.A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 486.023, Florida Statutes:

Dr. Jason Cirolia
7 Slow Stream Way
Ormond Beach, Florida 32174

as a member of the Board of Physical Therapy, filling a vacant seat previously occupied by Patrick Pabian, subject to confirmation by the Senate. This appointment is effective February 2, 2024, for a term ending October 31, 2026.

Sincerely,

Ron DeSantis
Governor

RD/ah

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

RECEIVED

2024 MAR -1 AM 10:41

DIVISION OF ELECTIONS
TALLAHASSEE, FL

STATE OF FLORIDA

County of Florida

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

Board of Physical Therapy Practice
(Name of Office)

on which I am now about to enter, so help me God.

[**NOTE:** If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

Signature

(Affix Seal Below)

Sworn to and subscribed before me by means of X *physical presence*
Or ___ *online notarization this* 21 *day of* Feb, 20 24.

Eleanor Styno
Signature of Officer Administering Oath or of Notary Public

ELEANOR STYNO
Notary Public
State of Florida
Comm# HH197548
Expires 11/11/2025

Eleanor Styno
Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known ☐ *or Produced Identification* ☐
Type of Identification Produced Drivers License

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: Home ☒ Office ☐

7 Slow Stream Way
Street or Post Office Box

Ormond Beach, FL 32174
City, State, Zip Code

Jason Cirulia
Print Name

Signature

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
409 The Capitol

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5229

DATE	COMM	ACTION
3/14/25	SM	Favorable
3/19/25	JU	Favorable
3/31/25	HP	Favorable
	RC	

March 14, 2025

The Honorable Ben Albritton
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 22** – Senator Rodriguez
HB 6525 – Representative Antone
Relief of Eric Miles, Jr. and Jennifer Miles by the South Broward Hospital District

SPECIAL MASTER'S FINAL REPORT

THIS IS A SETTLED EXCESS JUDGMENT CLAIM FOR $200,000. THE PARENTS OF E.E.M., NOW DECEASED, SEEK COMPENSATION FROM THE SOUTH BROWARD HOSPITAL DISTRICT D/B/A JOE DIMAGGIO CHILDREN'S HOSPITAL FOR ALLEGED MEDICAL MALPRACTICE COMMITTED DURING THE TREATMENT OF E.E.M.

FINDINGS OF FACT:

On December 24, 2017, E.E.M., the 17-month-old son of Eric Miles, Jr., and Jennifer Miles, was taken to the emergency department of Joe DiMaggio Children's Hospital (JDCH) in Broward County with complaints of an intermittent cough, irritability, and a decreased oral intake. He had radiographs taken and was discharged later that day. During the next 24 to 36 hours, his condition worsened, with additional symptoms of lethargy, fatigue, fever, diarrhea, and blood and mucus in his stools.

On December 26, 2017, E.E.M. returned to the emergency department of JDCH with lethargy and severe dehydration.

He was diagnosed with hypoglycemia, thrombocytopenia,[1] hepatitis, and abnormal blood clotting. His laboratory values were significantly abnormal. A perianal lesion was noted on admission. Due to having a distended abdomen, he was given an abdominal ultrasound, which indicated no inversion of one portion of the intestines within another. However, the abdominal ultrasound did indicate that there were issues with his appendix, and a clinical correlation was recommended.[2]

On December 27, 2017, E.E.M.'s distended abdomen had become tympanic, and he experienced tachycardia,[3] blood in his stool, and laboratory values that were still significantly abnormal. An abdominal X-ray taken later that day showed nonspecific gaseous bowel distension with air and stool through his large intestine.

E.E.M.'s condition worsened over the next few days, with his abdomen still distended, a perianal lesion that was worsening, and laboratory values that were still significantly abnormal.

On December 30, 2017, E.E.M. had a chest X-ray of his abdomen, which showed gaseous distension of the stomach with air identified in the abdomen. His laboratory values continued to be significantly abnormal.

On December 31, 2017, E.E.M. had a chest X-ray and babygram X-ray that both indicated gaseous gastric distension. He also had an abdominal ultrasound that showed complex fluid throughout his abdomen and pelvis and indicated that a CT scan could be performed if clinically warranted.

On January 1, 2018, the clinical record indicated that E.E.M. had not had a bowel movement in 3 days, with decreased bowel sounds and a distended abdomen.

---

[1] Thrombocytopenia occurs when one's bone marrow does not make enough platelets. Cleveland Clinic, *Thrombocytopenia,* https://my.clevelandclinic.org/health/diseases/14430-thrombocytopenia (last visited Feb. 4, 2025).

[2] A clinical correlation recommendation means that findings from a test or scan should be considered together with the patient's symptoms and overall health condition. This is because sometimes what is seen in a test might not be causing any problems, or it might be more serious than it appears. Balumed, *Clinical Correlation* (Dec. 26, 2023), https://balumed.com/en/medical-dictionary/clinical-correlation.

[3] Tachycardia is a heart rate that is faster than normal, or more than 100 beats per minute at rest. Cleveland Clinic, *Tachycardia,* https://my.clevelandclinic.org/health/diseases/22108-tachycardia (last visited Feb. 4, 2025).

On January 3, 2018, E.E.M. had an X-ray with contrast which indicated that the results were "suspicious" for small bowel obstruction, and an X-ray performed an hour later indicating that the results were "highly suspicious" for a small bowel obstruction. Additionally, a CT scan of his abdomen was performed and the associated report observed a small bowel obstruction, ascites,[4] and likely peritonitis,[5] among other things.

On January 4, 2018, E.E.M. had another X-ray with contrast of his chest and abdomen which showed that the contrast liquid did not advance through the small bowel, indicating an issue with obstruction. Although his symptoms, laboratory values, radiological, and other clinical findings were consistent with an intestinal blockage or rupture, JDCH's medical staff could not fully diagnose his condition.

On January 5, 2018, JDCH transferred E.E.M. to Holtz Children's Hospital at Jackson Memorial Hospital (Holtz Children's) in Miami-Dade County for an immunological consult – not for a surgical consultation. Upon admission to Holtz Children's, he was suffering from sepsis with multiorgan failure and other life-threatening conditions. He also underwent a CT scan that showed evidence of a bowel perforation.

On January 6, 2018, only hours after admission, E.E.M. underwent several emergency procedures: an exploratory laparotomy,[6] a small bowel resection,[7] an ileostomy,[8] and a

[4] Ascites is a build up of fluid in one's abdomen causing a swollen abdomen. Cleveland Clinic, *Ascites,* https://my.clevelandclinic.org/health/diseases/14792-ascites (last visited Feb. 4, 2025).
[5] Peritonitis is inflammation in one's peritoneum, which is the tissue that lines the inside of one's abdominal cavity. Cleveland Clinic, *Peritonitis,* https://my.clevelandclinic.org/health/diseases/17831-peritonitis (last visited Feb. 4, 2025).
[6] An exploratory laparotomy is surgery to open the abdomen to find the cause of problems that testing alone could not diagnose. Saint Luke's Health System, *Exploratory Laparotomy,* https://www.saintlukeskc.org/health-library/exploratory-laparotomy (last visited Feb. 4, 2025).
[7] Small bowel resection is surgery to remove a part of one's small bowel. It is done when part of one's small bowel is blocked or diseased. Mt. Sinai Health System, *Small bowel resection,* https://www.mountsinai.org/health-library/surgery/small-bowel-resection (last visited Feb. 4, 2025).
[8] An ileostomy is an opening in the abdominal wall that is made during surgery. It is usually needed because a problem is causing the ileum (the lowest part of the small intestine) to not work properly, or a disease is affecting that part of the colon and it needs to be removed. American Cancer Society, *What Is an Ileostomy?,* https://www.cancer.org/cancer/managing-cancer/treatment-types/surgery/ostomies/ileostomy/what-is-ileostomy.html (last visited Feb. 4, 2025).

mucous transverse colostomy fistula.[9] Over the next few weeks, he had numerous other surgeries associated with small bowel obstruction.

By January 11, 2018, E.E.M. had developed abdominal compartment syndrome and was draining foul-smelling fluid from around his ostomy[10] along with elevated infectious markers. The physicians at Holtz Children's suspected he had intraabdominal abscess and pus collection. Accordingly, he was taken back into surgery, which included an exploratory laparotomy, an abdominal washout, drainage of the intraabdominal abscess, takedown of both the ostomy and a temporary closure of the abdominal wall, and a debridement and drainage of necrotic tissue in the area of the perineum and anus.

On January 13, 2018, E.E.M. had another abdominal washout and drainage of the intraabdominal abscess. He also had a reapplication of the temporary abdominal closure with a silo bag.

On January 16, 2018, E.E.M. underwent a reopening of the recent laparotomy, and another abdominal washout and temporary abdominal closure.

On January 19, 2018, E.E.M. underwent another exploratory laparotomy, abdominal washout, partial closure of the abdominal wall fascia, and application of a Gore-Tex mesh for closure of the abdominal wall.
After January 19, 2018, E.E.M. underwent more than 20 additional surgeries and procedures and was hospitalized for extended periods of time (days and months).

Ultimately, E.E.M. suffered many life-altering and horrific injuries and damages, such as significant anal dilation; kidney stones; the loss of his terminal ileum, right colon, omentum, and appendix; and later, the removal of his entire remaining

[9] A mucous fistula procedure takes place at the same time as an ileostomy. It brings a section of the large or small intestine to a surgically created opening in one's abdominal skin (a stoma). A mucous fistula is a second stoma that allows one's body to expel intestinal mucus. Cleveland Clinic, *Mucous Fistula,* https://my.clevelandclinic.org/health/treatments/22844-mucous-fistula (last visited Feb. 4, 2025).
[10] An ostomy is a surgery that creates an opening in one's abdomen, changing the way waste exits one's body. Cleveland Clinic, *Ostomy,* https://my.clevelandclinic.org/health/procedures/22496-ostomy (last visited Feb. 4, 2025).

intestine. He also missed significant developmental milestones.

On September 1, 2023, E.E.M. passed away at 7 years of age.

LITIGATION HISTORY:

On May 28, 2020, Eric Miles, Jr. and Jennifer Miles filed a medical malpractice lawsuit in the Seventeenth Judicial Circuit, in and for Broward County, case no. 20-008839, against the South Broward Hospital District (doing business as JDCH) and several other parties.

Specifically, the lawsuit alleged medical negligence claims against the South Broward Hospital District (Count 1); Kidz Medical Services, Inc. (Count 2); Aymin Delgado-Borrego, M.D. (Count 3); and Neeraj Kumar Raghunath, M.D. (Count 4). It also alleged that the South Broward Hospital District was vicariously liable for the acts of David Drucker, M.D. (Count 5), Julie Ann Long, M.D. (Count 6), Gary Birken, M.D. (Count 7), Tamar Leah Levene, M.D. (Count 8), Alejandro Cracco, M.D. (Count 9), and Morris Sasson, M.D. (Count 10). The lawsuit also alleged that Kidz Medical Services, Inc., was vicariously liable for the acts of Aymin Delgado-Borrego, M.D. (Count 11), Neeraj Kumar Raghunath, M.D. (Count 12), and Gerard Jerome Minor, P.A. (Count 13).

On May 15, 2024, Mr. and Mrs. Miles, as the co-personal representatives of E.E.M., entered into a settlement agreement with the South Broward Hospital District, together with the hospital district's insurers, agents, employees, commissioners, appointees, trustees, and attorneys, all individually and in their official capacities. The settlement agreement provides for the payment of $300,000 to Mr. and Mrs. Miles pursuant to the statutory limit under s. 768.28, F.S.; the entry of a consent judgment in the amount of $200,000; and the hospital district's agreement that it supports a claim bill in the amount of $200,000.

A claim bill hearing was held on January 28, 2025, before the House and Senate special masters. Attorney Sean Cleary appeared with his clients, claimants Mr. and Mrs. Miles, and presented their case. Jason Unger and M. Katherine Hunter, who represent the South Broward Hospital District, were also present and available for questions from the special masters.

Because the hospital district agreed that it would not oppose the claim bill, its attorneys did not present any theories, arguments, witnesses, or evidence on the hospital district's behalf. They also did not object to any portion of Mr. Cleary's presentation. Ms. Hunter stated that the hospital district supports the settlement agreement and does not oppose the claim bill, but otherwise both she and Mr. Unger were silent throughout the hearing. The hospital district has not admitted fault in this claim.

CONCLUSIONS OF LAW:

JDCH is a public, not-for-profit hospital in Hollywood, Florida, which is operated by the South Broward Hospital District. Under the legal doctrine of *respondeat superior*, the hospital district is liable for its employees' wrongful acts or medical negligence committed within the scope of their employment.

When a plaintiff seeks to recover damages for a personal injury and alleges that the injury resulted from the negligence of a health care provider, the plaintiff bears the legal burden of proving, by the greater weight of the evidence, that the alleged actions by the health care provider were a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care is defined in statute as "that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."[11]

The "greater weight of the evidence" burden of proof means the more persuasive and convincing force and effect of the entire evidence in the case.[12] Put another way, if each party's evidence is placed on a balance scale, the side that dips down, even by the smallest amount, has met the burden of proof by the greater weight of the evidence.

The elements of a medical malpractice action are: (1) a duty by the physician, (2) breach of that duty, and (3) causation. Injury or damages must also be demonstrated. Florida follows the 'more likely than not' standard in proving causation, i.e., that the negligence 'probably caused' the plaintiff's injury.[13]

[11] Section 766.102(1), F.S.
[12] Fla. Std. Jury Instr. (Civ.) 401.3, *Greater Weight of the Evidence.*
[13] *Ruiz v. Tenet Hialeah Healthsystem, Inc.,* 260 So. 3d 977, 981 (Fla. 2018).

These elements as outlined below are based upon depositions, testimony, and other information submitted both before and during the special master hearing.

Duty

A healthcare provider, acting through its employees and agents, generally has a duty to provide medical care and treatment to its patients. Such medical care and treatment must be consistent with the prevailing professional standard of care.

In this case, JDCH and its medical staff had a duty to meet the prevailing professional standard of care by properly evaluating, diagnosing, and treating E.E.M.'s small bowel obstruction.

Breach of Duty

Based upon the undisputed facts already outlined above and otherwise appearing in the record, it is evident that JDCH medical staff breached the duty of care it owed E.E.M. by failing to properly evaluate, diagnose, and treat his small bowel obstruction.

E.E.M.'s clinical presentation, signs, symptoms, laboratory values, radiology findings, and other clinical findings, which worsened daily, were all consistent with an intestinal blockage and possible intestinal rupture. However, JDCH medical staff failed to properly diagnose E.E.M. It was not until after JDCH transferred him to Holtz Children's on January 5, 2018, that he received a proper diagnosis.

Dr. Chad Thorson, the pediatric surgeon at Holtz Children's who operated on E.E.M. soon after he was transferred there, testified in his pre-trial deposition, which was submitted into evidence, that he examined E.E.M.'s abdomen and observed that it was enlarged (i.e. distended) and tympanic. He also noted that E.E.M. suffered from peritonitis, which is where any slight movement of the patient causes excruciating pain. He also suffered from a perianal lesion. Because these symptoms alone were not definitive, Dr. Thorson immediately ordered a CT scan, which revealed that E.E.M. had large amounts of air and fluid in his abdomen and fat stranding, which is an inflammatory response.

To confirm a diagnosis of intestinal blockage or intestinal rupture, Dr. Thorson performed an exploratory laparotomy on what was by then a critically ill child. Upon entering E.E.M.'s abdomen on January 6, 2018, Dr. Thorson encountered significant amounts of intra-abdominal fluid known as succus, which had escaped from four perforations in E.E.M.'s intestines. He also observed that the digestive enzymes in the succus had effectively dissolved E.E.M.'s rectum from the inside out and were the apparent cause of his perianal lesion, the existence of which had been noted in his medical records since at least December 26, 2017. E.E.M.'s omentum – a fatty intestinal covering that functions to fight infection and wrap around bowel injuries – had had sufficient time to wrap around his bowel perforations. Numerous adhesions had also formed.

Dr. Thorson testified in his deposition that the human body is not able to form these kinds of adhesions and inflammatory process within a relatively short (acute) amount of time, as in hours or a few days. Considering the amount of succus he observed in E.E.M.'s abdomen, the existence of the perianal lesion, the wrapping of intestinal perforations by the omentum, and the numerous adhesions he encountered, Dr. Thorson testified that in his medical opinion, E.E.M.'s perforations had more likely than not occurred several days or weeks before his surgery, either before he was admitted to JDCH, or while he was still a patient there.

Dr. Thane Blinman, a pediatric surgeon at the Children's Hospital of Philadelphia and an Associate Professor of Surgery at the University of Pennsylvania, was asked to review E.E.M.'s records and give his professional opinions regarding his treatment at JDCH and Holtz Children's. His pre-trial deposition was submitted into evidence.

Dr. Blinman testified that when it comes to evaluating a child for a "surgical abdomen" (an abdomen requiring emergency surgery) due to a possible bowel perforation, surgeons look for distension, evidence of obstruction like emesis (no bowel movements), inability of contrast to move through the bowel, tenderness upon palpitation, and redness or shininess of the abdomen. The record reflects that E.E.M presented with all these symptoms while admitted as a patient at JDCH.

According to Dr. Blinman, E.E.M. was already septic when he was first admitted to JDHC on December 26, 2018. There was some sort of bowel injury in progress by that time. E.E.M. had blood and mucous stool in his stool the day before. He was very likely suffering from some kind of irreversible mucosal bowel injury that needed to be confirmed via a surgical laparotomy as soon as possible to prevent further damage to his intestine. Although the surgeons at JDCH (and others including E.E.M.'s own parents, who suggested it might be appropriate) clearly considered exploratory surgery a *potential* option, they never actually recommended it or performed it.

In sum, based upon the evidence in the record, JDCH's medical staff breached the prevailing professional standard by failing to:

- Recognize the severity of E.E.M.'s clinical condition, which suggested the likelihood of bowel obstruction and perforation.
- Recognize, diagnose, and treat E.E.M.'s surgical abdomen.
- Recognize, diagnose, and treat E.E.M.'s perianal ulcer, which suggested a surgical abdomen.
- Order appropriate imaging and treatment for E.E.M., including an earlier CT scan and repeat CT scan.
- Recommend surgery, including exploratory laparotomy, on E.E.M.
- Perform an exploratory laparoscopy or an exploratory laparotomy on E.E.M.
- Transfer E.E.M. to another hospital if further treatment to address his surgical condition was not going to be provided at JDCH.

Accordingly, I find that JDCH breached its duty to provide E.E.M. medical care and treatment consistent with the prevailing professional standard of care.

Causation

Based upon the undisputed facts already outlined above and otherwise appearing in the record, it is evident that JDCH medical staff's failure to properly evaluate, diagnose, and treat E.E.M.'s condition was the direct and proximate cause of his injuries and damages.

According to Dr. Blinman, if E.E.M.'s condition had been properly evaluated, diagnosed, and treated at JDCH, he would have avoided some or even all of the surgeries and treatments he required.

On January 3, 2017, a belated CT scan of E.E.M.'s abdomen was performed at JDCH and the associated report observed small bowel obstruction, ascites, and likely peritonitis, among other things. Had the surgeons at JDCH immediately operated on E.E.M. on or before that date, E.E.M. more likely than not would have only needed the relatively small, irreversibly damaged section of his intestine removed, and an ostomy put in place, which could have been reversed at a later time. However, because the surgeons did not operate on him on or before that date, E.E.M. would later go on to lose nearly the entirety of his intestine and require over 20 additional surgeries and treatments, including placement of a Total Parenteral Nutrition (TPN) tube.[14] He would also require an intestinal transplant, for which he was preparing when he died.

Additionally, Dr. Steven N. Lichtman, an expert pediatric gastroenterologist that claimants intended to present at trial, corroborated Dr. Blinman's position in a response to interrogatories (submitted into evidence). He opined that E.E.M. was forced to undergo many additional treatments, including lengthy hospitalizations, surgeries, and the removal of his entire remaining intestine, as a direct and proximate result of JDCH medical staff's negligence, which in turn caused or contributed to his death.

Accordingly, I find that JDCH's breach of the duty of care it owed E.E.M. was the direct and proximate cause of his injuries and damages, including his death.

Injury or Damages

Based upon the undisputed facts already outlined above and otherwise appearing in the record, it is evident that JDCH's medical malpractice has caused both E.E.M. and his family an enormous amount of physical and emotional pain and suffering.

[14] A TPN is method of feeding that bypasses the gastrointestinal tract. Cleveland Clinic, *Parenteral Nutrition,* https://my.clevelandclinic.org/health/treatments/22802-parenteral-nutrition (last visited Feb. 4, 2025).

As noted earlier in this report, E.E.M. suffered many life-altering and horrific injuries and damages, including anal dilation; kidney stones; the loss of his terminal ileum, right colon, omentum, and appendix; and the removal of his entire remaining intestine. He also missed important developmental milestones. He died on September 1, 2023.

Moreover, Dr. Blinman testified that E.E.M.'s quality of life was severely impacted. For example, had E.E.M. lived beyond September 1, 2023, and received a bowel transplant (he never did), he never would have been able to eat a cheeseburger. Attending school never would have been normal. He was also unlikely to ever be on a varsity team for sports.

Dr. Blinman also testified that the total removal of E.E.M.'s intestine adversely impacted his life expectancy. Individuals lacking an intestine can develop severe liver failure from TPN feedings or die from complications with the central line. Children with a normal bowel do not have these problems. Similarly, bowel transplants in individuals needing a transplant may or may not be successful (the failure rate is very high), and if an individual's body rejects the transplant, it is often fatal.

Claimants also submitted a summary of the past and present value of future economic losses to E.E.M. based upon his life care plan. Life care plans are intended to formulate medical valuations that identify a subject's residual medical conditions and future care requirements, and they quantify the costs of those requirements in monetary terms.[15] According to Gary A. Anderson, Ph.D., an expert hired by claimants to develop the summary, due to JDCH medical staff's negligence, had E.E.M. lived beyond 18 years of age to 67 years of age, he would have lost $949,178 in earning capacity over his lifetime. And as measured from age 7 (his age at the time of his death), he would have required $75,146,544 in medical care through age 73.

Accordingly, I find that E.E.M. endured many life-altering and horrific injuries and damages, including his death, due to the

[15] Physician Life Care Planning, *Frequently Asked Questions About Life Care Plans and Life Care Planning,* https://www.physicianlcp.com/faqs/life-care-planning/ (last visited Jan. 31, 2025).

medical malpractice of JDCH's medical staff. He also would have sustained significant economic losses had he lived beyond 7 years of age.

Final Conclusion in Light of the Evidence

The greater weight of the evidence made available to the special masters indicates that Mr. and Mrs. Miles would have likely prevailed at trial in its medical malpractice claims against the South Broward Hospital District, which is vicariously liable for the acts and omissions of JDCH's medical staff.

Because the hospital district agreed in the settlement agreement that it would not oppose the claim bill, its attorneys did not present any theories, arguments, witnesses, or evidence on the hospital district's behalf at the hearing. They also did not object to any portion of the claimants' presentation. It is therefore impossible, based solely on the record developed before the special masters, to assess the merits of any potential defenses that the hospital district might have made had the matter proceeded to trial.

Although the deposition transcripts of both Drs. Thorson and Blinman indicate that E.E.M. suffered from a genetic disorder called Schwachman-Diamond Syndrome,[16] and there was some suggestion by the hospital district's attorneys that the disorder could have complicated E.E.M.'s diagnosis and treatment, that argument is not well developed in the record before the special masters.

Similarly, there is evidence in the record that E.E.M. was also suffering from severe influenza symptoms when he was admitted to JDCH. Such symptoms could have masked, to some extent, E.E.M.'s other symptoms suggesting he had a bowel obstruction (e.g. fever, fatigue, cough, and diarrhea)[17] and made it more difficult for JDCH's medical staff to diagnose and treat his small bowel obstruction. However, this argument

[16] Shwachman-Diamond Syndrome is a rare, inherited bone marrow failure, characterized by a low number of white blood cells, poor growth due to difficulty absorbing food, and, in some cases, skeletal abnormalities. Boston Children's Hospital, *Shwachman-Diamond Syndrome,* https://www.childrenshospital.org/conditions/shwachman-diamond-syndrome (last visited Feb. 3, 2025).
[17] Signs and symptoms of the flu include fever, fatigue, cough, and diarrhea, all of which E.E.M. suffered while at JDCH. Centers for Disease Control, *Signs and Symptoms of Flu* (Aug. 26, 2024), https://www.cdc.gov/flu/signs-symptoms/index.html.

is also not well developed in the record before the special masters.

Based upon the evidence made available to the special masters, and considering the costs of litigation and the uncertainty of juries, I conclude that the settlement agreement is reasonable under the circumstances.

SETTLEMENT AGREEMENT

In accordance with the terms of its settlement agreement with Mr. and Mrs. Miles, the South Broward Hospital District did not present evidence or make any arguments during the *de novo* special master hearing. However, based upon the questions asked by the hospital district's attorneys in the deposition transcripts provided by claimants, it appears that the hospital district, at least initially, intended to dispute the negligence allegations.

The parties settled this suit for $500,000, of which $300,000 has already been paid. Consistent with the settlement agreement, claimants are seeking approval from the Legislature for the difference of $200,000, which would be paid out of hospital district funds or insurance.

Should the claim bill pass, the proceeds would be distributed first to pay attorney fees of 25 percent of $200,000 ($50,000), then the remainder would go to claimants. Claimants indicated at the claim bill hearing that there are no outstanding costs to be paid.

The settlement agreement, dated April 5, 2024 and fully executed by the parties on May 15, 2024, states that neither the payments nor the negotiations for the agreement (including all statements, admissions, or communications) by the plaintiffs, defendants, or their attorneys or representatives may be considered admissions by any of said parties and that no past or present wrongdoing on the part of the defendants may be implied by such payments or negotiations. The hospital district does not oppose the claim bill.

Claimants settled their claims against defendant Kidz Medical Services, Inc. and its physicians sometime before the claim bill hearing. The terms of that settlement agreement are confidential and therefore were not disclosed in the claim bill hearing.

ATTORNEY FEES: Florida law limits the claimants' attorney fees to 25 percent of the claimants' total recovery by way of any judgment or settlement obtained pursuant to section 768.28, of the Florida Statutes. The claimants' attorney has acknowledged this limitation and verified in writing that nothing in excess of 25 percent of the gross recovery will be withheld or paid as attorney fees.

RECOMMENDATIONS: The undersigned recommends that certain factual representations in the bill be amended for accuracy; specifically, that on January 1, 2018, the clinical record indicated that E.E.M. had not had a bowel movement in 3 days (not 8 days), and that the South Broward Hospital District has paid claimants the statutory limit of $300,000 in damages under section 768.28 of the Florida Statutes.

Based upon the foregoing, the undersigned recommends that Senate Bill 22 be reported FAVORABLY.

Respectfully submitted,

Mike Collazo
Senate Special Master

cc: Secretary of the Senate

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 19, 2025

I respectfully request that **Senate Bill #22** relating to Relief of Eric Miles, Jr., and Jennifer Miles by the South Broward Hospital District, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 40

File signed original with committee office

Tab 7

The Florida Senate

APPEARANCE RECORD

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

4-1-25	SB 22
Meeting Date	Bill Number or Topic
Health Policy	
Committee	Amendment Barcode (if applicable)

Name Jason Unger

Phone 850-577-9090

Address 301 S. Bronough Street #600
Street

Email Junger@gray-robinson.com

Tallahassee FL 32312
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
South Broward Hospital District

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

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

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

S-001 (08/10/2021)

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
409 The Capitol

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5229

DATE	COMM	ACTION
3/20/25	SM	Favorable
3/25/25	JU	Favorable
04/01/25	HP	Fav/CS
	RC	

March 20, 2025

The Honorable Ben Albritton
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **CS/SB 28** – Senator Martin
HB 6523 – Representative Tuck
Relief of Darline Angervil by the South Broward Hospital District

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM BILL FOR LOCAL FUNDS IN THE AMOUNT OF $6,100,000, PAYABLE FROM UNENCUMBERED FUNDS OF THE SOUTH BROWARD HOSPITAL DISTRICT, BASED ON A SETTLEMENT AGREEMENT BETWEEN DARLENE ANGERVIL AND THE DISTRICT. THE SETTLEMENT AGREEMENT RESOLVED A CIVIL ACTION THAT AROSE FROM THE ALLEGED NEGLIGENCE OF THE DISTRICT THAT CAUSED INJURIES TO MS. ANGERVIL AND HER CHILD, J.R., A MINOR.

FINDINGS OF FACT:

On January 14, 2014, Darline Angervil (then known as Darline Rocher), just over 30 weeks pregnant, was admitted to Memorial Hospital West, a hospital owned by the South Broward Hospital District (District). Ms. Angervil went to the hospital concerned about decreased fetal movement, hypertension, and headaches. Her obstetrician, Dr. Emil Abdalla, ordered continuous fetal monitoring and that her vital signs be taken at least once every two hours. Records show that her blood pressure was elevated throughout the day of January 14, including a systolic blood pressure of 160 mm or

higher on two occasions at least four hours apart. Ms. Angervil was diagnosed with preeclampsia with severe features, making this a high-risk pregnancy.

Preeclampsia is a condition that remains during the remainder of the pregnancy until the baby is delivered. The objective was to treat the mother with medications and rest, monitor the mother and baby, hoping to delay delivery until it was considered safe and prudent to deliver the baby.

Throughout the following two days, January 15 and 16, records show that Ms. Angervil continued to complain about headaches. One of these headaches, on January 16, Ms. Angervil rated 7 out of 10 on the severity scale. Nurse Melanie Wells, a District employed labor and delivery nurse, began her shift on January 16 at 7:00 p.m., and was assigned to Ms. Angervil.

At approximately 8:25 p.m. on January 16, Nurse Wells contacted Dr. Abdalla to request an order to remove the continuous electronic fetal heart rate monitor. At 8:27 p.m., Dr. Abdalla provided Nurse Wells with a telephone order to remove the electronic fetal monitor. The records and testimony provided do not show that Nurse Wells notified Dr. Abdalla of Ms. Angervil's consecutive high blood pressure readings, the fetal monitoring strip showing a prolonged deceleration some 9 minutes earlier, or the headaches when she requested the order removing the monitor.

Expert testimony provided to the Special Master opined that Nurse Wells, when requesting removal of the monitor, should have specifically mentioned to Dr. Abdalla that the patient had complained of a headache off and on throughout the afternoon hours requiring treatment; that the fetal monitoring had exhibited prolonged decelerations; and that the blood pressures were trending up. The expert testimony concluded that Nurse Wells should have advocated to continue fetal monitoring rather than for the monitor to be removed.

That evening, Ms. Angervil continued to have consecutive abnormal blood pressure readings at 8:29 p.m. (149/89), 9:07 p.m. (153/90), 9:24 p.m. (159/91), and 10:33 p.m. (156/89). Nurse Wells did not put the fetal monitor back on Ms. Angervil or notify Dr. Abdalla of the continuing high blood pressure

readings. Blood pressure readings were not recorded after the 10:33 p.m. reading until 2:00 a.m. on January 17.

At 2:24 a.m. on January 17, Ms. Angervil called for the nurse complaining of headache, chest pain, and difficulty breathing. Nurse Wells initiated oxygen and checked Ms. Angervil's vital signs. At this time, J.R. was not being monitored. At 2.26 a.m., Ms. Angervil's blood pressure reading was dangerously high (194/104). A similar blood pressure reading at 2:28 a.m. (197/101) confirmed a hypertensive crisis. Additional extremely high blood pressure readings were recorded at 2:32 a.m. (196/102) and 2:37 a.m. (194/104). At 2:40 a.m., Nurse Wells called Dr. Abdalla's nurse midwife, despite directions that Dr. Abdalla was to be called directly, if needed. The nurse midwife told Nurse Wells she needed to call Dr. Abdalla. At 2:43 a.m., Nurse Wells contacted Dr. Abdalla, which call lasted four minutes. On the call, Dr. Abdalla ordered the administration of Hydralazine to lower Ms. Angervil's blood pressure, and at 2:54 a.m., records show the Hydralazine was administered.

After the call with Dr. Abdalla, Nurse Wells attempted to find fetal heart tones but was unable to do so. At 2:54 a.m., due to the difficulty in finding fetal heart tones, the nurse manager contacted an OB/GYN who was working on the floor, Dr. Gazon, to assist in detecting fetal heart tones with an ultrasound machine. At 2:56 a.m., critically low fetal heart tones were observed, whereby Dr. Gazon ordered an emergency cesarean section. Dr. Abdalla arrived at the Hospital and began the cesarean section at 3:05 a.m.

J.R. was delivered at 3:17 a.m. with an extremely low Apgar score of 0-1-3.[1] J.R. was noted to be flaccid (totally limp), cyanotic (bluish or purplish discoloration of the skin due to low blood oxygen levels), apneic (not breathing), and asystolic (no heart rate), essentially lifeless, resulting in emergency neonatal resuscitation. Within the first day, J.R. was transferred from Memorial West Hospital to Joe DiMaggio Children's Hospital for a higher level of care. J.R.'s birth, resuscitation, and subsequent course of neonatal treatment are consistent with a hypoxic injury around the time of delivery, and her medical records include numerous

[1] The Apgar score is a standardized assessment of a neonate's status immediately after birth and the response to resuscitation efforts. National Institute of Health, https://www.ncbi.nlm.nih.gov/books/NBK470569/ (visited February 12, 2025).

references to her "Birth-related hypoxia." J.R.'s treating physicians provided assessment notes describing the profound nature of J.R.'s catastrophic injuries and constant needs.

Brain ultrasound scans taken over a five-week period demonstrate that the injury to J.R. occurred at or near the time of her birth. According to expert testimony provided by neuroradiologist, Dr. Jerome Barakos, the brain ultrasound scan taken on:

- The afternoon of her birth, January 17, 2014, showed normal echogenicity throughout the brain without any abnormal findings for a premature infant;
- January 24, 2014, showed a characteristic injury to J.R.'s brain, which had not evolved to the point of being identifiable on that first scan; that at this point there had been enough time for the brain changes of injury to occur;
- February 24, 2014, showed a loss of brain volume, proving that there was damage so great, demonstrating atrophy.

Further testimony provided by Dr. Barakos opined that the course of a day or two is needed before the brain cells actually start changing shape and falling apart such that an injury of this type will show in a brain ultrasound scan. He stated that when these changes on the scan take at least a day or two before you can see those changes, the brain injury happened very close to the time of the first scan; that if the injury happened days before J.R.'s birth, the injury would have shown on the first scan.

LITIGATION HISTORY:

On March 7, 2016, Claimant filed a lawsuit against the District, Dr. Abdalla and his employer, and neonatologist Dr. Vicki Johnston and her nurse practitioner and their employer. In 2020, the claims against all the defendants except the District were settled. In September of 2022, the case proceeded to trial against just the District. After a six week trial, the jury was unable to reach a verdict and a mistrial was declared.

The second trial against the District began in October of 2023. During the second week of this trial, shortly after the Claimant rested their case, the parties reached a settlement. Pursuant to the settlement agreement, the District agreed to the entry of a consent judgment of $6.4 million, which was entered on September 6, 2024. The terms of the agreement required the District to pay the sovereign immunity limits of $300,000, with

the remaining $6.1 million balance to be paid upon the passage of a claim bill.

RESPONDENT'S POSITION: The District admits there was a deviation from the standard of care by the District related to the failure to monitor the fetal status of J.R. in a timely and adequate manner and the failure to notify the attending physician of Ms. Angervil's changes in status in a timely manner that caused a neurological injury to J.R. The District has agreed to support the claim bill.

CONCLUSIONS OF LAW: The claim bill hearing held on January 9, 2025, was a *de novo* proceeding to determine whether the District is liable in negligence for damages it may have caused to the Claimant and J.R., and, if so, whether the amount of the claim is reasonable. This report is based on evidence presented to the special master prior to, during, and after the hearing. The Legislature is not bound by settlements or jury verdicts when considering a claim bill, the passage of which is an act of legislative grace.

Section 768.28, of the Florida Statutes, limits the damages a claimant can collect from government entities as a result of its negligence or the negligence of its employees to $200,000 for one individual and $300,000 for all claims or judgments arising out of the same incident. Damages in excess of this limit may only be paid upon approval of a claim bill by the Legislature. Thus, the Claimant will not receive the full amount of the settlement unless the Legislature approves a claim bill authorizing additional payment.

Every claim bill must be based on facts sufficient to meet the "greater weight of the evidence" standard. The "greater weight of the evidence" burden of proof "means the more persuasive and convincing force and effect of the entire evidence in the case."[2] With respect to this claim bill, the Claimant proved that the District had a duty to the Claimant, the District breached that duty, and that the breach caused the Claimant's injuries and resulting damages.

Negligence
Negligence is "the failure to use reasonable care, which is the care that a reasonably careful person would use under

[2] Fla. Std. Jury Instr. (Civ.) 401.3, *Greater Weight of the Evidence*.

like circumstances";[3] and "a legal cause of loss, injury or damage if it directly and in natural and continuous sequence produces or contributes substantially to producing such loss, injury or damage, so that it can reasonably be said that, but for the negligence, the loss, injury or damage would not have occurred."[4]

There are four elements to a negligence claim: (1) duty – where the defendant has a legal obligation to protect others against unreasonable risks; (2) breach – which occurs when the defendant has failed to conform to the required standard of conduct; (3) causation – where the defendant's conduct is foreseeably and substantially the cause of the resulting damages; and (4) damages – actual harm.[5]

In this matter, the District's liability depends on whether the District's employee, Nurse Wells, violated the applicable standard of care during her shift that began on January 16, 2014, and whether this breach caused the resulting injuries to Ms. Angervil and J.R.

Duty

A legal duty may arise from statutes or regulations; common law interpretations of statutes or regulations; other common law precedent; and the general facts of the case.[6] A health care provider generally has a duty when providing health care services, to provide such services in a non-negligent manner. This duty is known as the "standard of care." Section 766.102(1), of the Florida Statutes, establishes that the prevailing professional standard of care in a medical malpractice claim against a health care provider is "that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers." The standard of care in medical malpractice cases is determined through consideration of expert testimony.[7]

Under the doctrine of *respondeat superior*, an employer is liable for acts of employees performed within the course of

[3] Fla. Std. Jury Instr. (Civ.) 401.4, *Negligence*.
[4] Fla. Std. Jury Instr. (Civ.), 401.12(a) - *Legal Cause, Generally*.
[5] *Williams v. Davis*, 974 So. 2d 1052, 1056 (Fla. 2007). *See also* Fla. Std. Jury Instr. (Civ.) 401.4, *Negligence*.
[6] *McCain v. Fla. Power Corp*., 593 So. 2d 500, 503 n. 2 (Fla. 1992).
[7] *Pate v. Threlkel*, 661 So. 2d 278, 281 (Fla. 1995).

their employment.[8] In this matter, the District, and its employee, Nurse Wells, had a duty to provide its services in a non-negligent manner.

Breach
A preponderance of the evidence establishes that the District breached its duties by failing to render its services in a non-negligent manner by not continually monitoring the fetal heart tones during the evening of January 16, 2014, and into the early morning of January 17, 2014, as well as by failing to notify the attending physician of Ms. Angervil's changes in status in a timely manner. These failures led to the delay in the emergency delivery of J.R.

Causation
In order to prove negligence, the Claimant must show that the breach of duty caused the specific injury or damage to the plaintiff.[9] Proximate cause is generally concerned with "whether and to what extent the defendant's conduct foreseeably and substantially caused the specific injury that actually occurred."[10] To prove proximate cause, the Claimant generally must submit evidence that there is a sequence between the District's negligence and the Claimant's injuries such that it can be reasonably said that but for the District's negligence, the injuries would not have occurred.

In this matter, the injuries suffered by J.R. were the direct and proximate result of the District's failure to fulfill its duties in a non-negligent manner. Expert testimony showed that had the fetal heart tones been monitored continually:

- It would have shown sooner that J.R. was in fetal distress.
- That the cesarean section would have been performed sooner.
- That J.R. would have been delivered before the oxygen deprivation could have caused her neurological injuries.

Damages
J.R.'s birth-related medical record is consistent with a hypoxic injury around the time of delivery, and her medical records are replete with discussions of her "birth-related hypoxia" (oxygen deprivation at birth). The Claimant has established that J.R.

[8] *Dieas v. Associates Loan Co.,* 99 So. 2d 279, 280-281 (Fla. 1957); *Stinson v. Prevatt*, 94 So. 656, 657 (Fla. 1922).
[9] *Stahl v. Metro Dade Cnty.*, 438 So. 2d 14 (Fla. 3rd DCA 1983).
[10] *Dept. of Children and Family Svcs. v. Amora*, 944 So. 2d 431, 435 (Fla. 4th DCA 2006).

suffered irreversible neurological injuries during labor and delivery due to lack of oxygen. The challenges and disabilities that she now faces are consistent with, and caused by, the birth injury that she experienced. J.R. is expected to live into her fifties.

The record demonstrates that the nature of J.R.'s injuries and constant needs resulting from her injuries at birth includes mixed quadriparetic cerebral palsy related to hypoxic ischemic encephalopathy, global profound developmental delay, periventricular leukomalacia, constipation, dysphagia, failure to thrive, gastrostomy tube placement, seizure disorder, esophagitis, dystonia and dyskinesias, and impairment of mobility and communication/cognition.

According to J.R.'s doctors, as well as Respondent's own medical evaluations, she will require care of a licensed practical nurse 24 hours a day and continued highly specialized medical care which include physicians, nursing, physical therapy, occupational therapy, speech therapy, orthotists, durable medical equipment, supplies, and surgeries. J.R. is tube-fed and will remain severely cognitively impaired with seizure disorder, nonambulatory, and totally dependent for all activities of daily living.

A Life Care Plan was created for J.R. to determine the needs she has as a direct consequence of the injuries. Raffa Consulting Economists, Inc., created a report based on the Life Care Plan that estimated the present value of the combined economic loss over J.R.'s life for lost wages, medical, educational and support services, as well as ancillary services of transportation, housing and personal items, is between $26,741,930 and $27,570,135. This amount does not include any non-economic damages for J.R., nor any loss, economic or noneconomic, to Ms. Angervil.

The Claimant's attorney asked the jury for a verdict of approximately $45 million in the first trial of this case. It is possible that the jury in the second trial could have found the District 100% at fault and liable for the $45 million award. The Guardian ad Litem appointed by the court for J.R. fully supports the settlement and believes it constitutes an excellent recovery for J.R. and her mother. It is the Guardian's recommendation the settlement, as well as the Claimant's

proposed allocation, be approved as it is in the best interest of J.R.

Should the full amount of the claim bill be awarded, the Claimant proposes the following allocations:

Attorney and Lobbyist Fees (25%)	$1,525,000
Costs[11]	690,107
Medicaid and Health Liens	156,497
J.R. Special Needs Trust	3,000,000
Darline Angervil	728,396
	$6,100,000

As a result of the consent agreement entered by the parties and by the court, the District has paid $300,000 (the maximum allowed under the state's sovereign immunity waiver) with the remaining $6.1 million to be paid if this claim bill is passed by the Legislature and becomes law. The District has an insurance policy that will pay the amount awarded over $2 million.

Based upon the arguments and documents provided before, during, and after the special master hearing, the undersigned believes that the settlement, and the Claimant's proposed allocation, represent a proper and fair agreement.

COLLATERAL SOURCES OF RECOVERY:

The original lawsuit in this matter included as defendants Dr. Abdalla and his employer, and neonatologist Dr. Vicki Johnston and her nurse practitioner and their employer. In 2020, the claims against these defendants were settled for $6,500,000. Of funds paid from this Court-approved settlement with the other defendants, $2,000,000 was placed in a Special Needs Trust for J.R.; $1,150,000 was used to purchase a Structured Settlement for J.R.; $186,919 went to Darline Angervil; and $699,234 was held in trust to partially resolve medical liens ($419,260 in lien reductions from negotiations were distributed to Ms. Angervil).

ATTORNEY FEES:

Attorney fees may not exceed 25 percent of the amount awarded.[12] The Claimant's attorney has agreed to limit attorney and lobbying fees to 25 percent of any amount awarded by the Legislature.

[11] This amount reflects the current costs prior to the Special Master hearing. Claimant's attorneys have agreed to absorb the additional costs incurred for the hearing and going forward from the Claimant's attorney's fees.
[12] *See* s. 768.28(8), F.S.

RECOMMENDATIONS:

Recommended Amendments
Lines 140–144 of the claim bill should be amended to reflect the allocation of the award between J.R. and Darline Angervil, with the funds going to J.R. directly paid to the Special Needs Trust created for her benefit.

Recommendation on the Merits
The greater weight of the evidence in this matter demonstrates that the negligence of the District's employee was the legal proximate cause of the injuries and damages suffered by J.R. and her mother, Darline Angervil. The damage award agreed upon by the parties is well within the actual damages suffered by J.R. and Ms. Angervil.

Accordingly, I recommend that SB 28 be reported FAVORABLY, with recommended amendments, in the amount $6.1 million, with the portion of funds allocated for the benefit of J.R. being paid into a Special Needs trust established for J.R.

Respectfully submitted,

Tom Thomas
Senate Special Master

cc: Secretary of the Senate

CS by Health Policy:
The committee substitute allocates the funds between J.R. and her mother, Darline Angervil, as recommended by the Claimant's attorneys and approved by J.R.'s Guardian ad Litem. The amendment provides that $3.1 million is payable to Darline Angervil and $3.0 million is payable to an irrevocable trust created for the exclusive use and benefit of J.R.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
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The Committee on Health Policy (Martin) recommended the following:

Senate Amendment (with title amendment)

Delete lines 142 - 143
and insert:
encumbered and to:
(1) Draw a warrant in the sum of $3.1 million payable to Darline Angervil as compensation for injuries and damages sustained; and
(2) Draw a warrant in the sum of $3 million payable to an irrevocable trust created for the exclusive use and benefit of

883178

J.R. as compensation for injuries and

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

And the title is amended as follows:

Delete line 6

and insert:

guardian of J.R., and J.R. for injuries and damages sustained

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Criminal Justice, *Chair*
Appropriations Committee on Criminal and Civil Justice, *Vice Chair*
Appropriations
Appropriations Committee on Transportation, Tourism, and Economic Development
Banking and Insurance
Rules
Transportation

SENATOR JONATHAN MARTIN
33rd District

March 2128, 2025

RE: SB 28: Relief of Darline Angervil and J.R. by the South Broward Hospital District

Dear Chair Burton,

Please allow this letter to serve as my respectful request to place SB 28: Relief of Darline Angervil and J.R. By the South Broward Hospital District on the next committee agenda.

Your kind consideration of this request is greatly appreciated. Please feel free to contact my office for any additional information.

Sincerely,

Jonathan Martin
Senate District 33

REPLY TO:
❒ 2000 Main Street, Suite 401, Fort Myers, Florida 33901 (239) 338-2570
❒ 315 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5033

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

Tab 8

The Florida Senate

APPEARANCE RECORD

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

4-1-25	SB 28
Meeting Date	Bill Number or Topic
Health Policy	
Committee	Amendment Barcode (if applicable)

Name Jason Unger

Phone 850-577-9090

Address 301 S. Bronough Street #600
Street

Email Junger@gray-robinson.com

Tallahassee FL 32312
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
South Broward Hospital District

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

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

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 306
INTRODUCER:	Health Policy Committee and Senators Sharief and Gaetz
SUBJECT:	Managed Care Plan Network Access
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 306 amends s. 409.967, F.S., to require the Florida Agency for Health Care Administration (AHCA) to establish specific standards to ensure enrollees have access to network providers during state holidays and outside regular business hours.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

The Florida Agency for Health Care Administration

The Florida Agency for Health Care Administration (AHCA) is created under s. 20.42, F.S., to be the chief health policy and planning entity for the state, responsible for health facility licensure, inspection, and regulatory enforcement,[1] as well as the administration of Florida's Medicaid program.[2]

[1] Florida Agency for Health Care Administration, *Health Quality Assurance, available at* https://ahca.myflorida.com/health-quality-assurance (last visited Mar. 27, 2025).
[2] Section 409.902, F.S.

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[3] The federal Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services is responsible for administering the Medicaid program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians and is financed through state and federal funds.[4]

Statewide Medicaid Managed Care

Approximately 72.5 percent of Florida Medicaid recipients[5] receive services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[6] The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and the Prepaid Dental Health program.[7] Among these three components, Florida's SMMC program offers a health care package covering acute, preventive, behavioral health, prescribed drugs, long-term care, and dental services. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.[8]

The AHCA awarded contracts to the current SMMC managed care plans through a competitive procurement process called an Invitation to Negotiate (ITN). The AHCA awarded and executed new contracts for SMMC 3.0 in October 2024 and officially rolled out the new SMMC 3.0 program on February 1, 2025.[9] The rate year for the SMMC contracts is October 1 through September 30 of each contract year.[10]

Managed care plans providing MMA program services are required to cover acute, preventive, and other health care services, such as:[11]

- Hospital services;
- Physician services;
- Pharmacy services;
- Behavioral health services;

[3] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid (last visited Mar. 27, 2025).
[4] Section 20.42, F.S.
[5] The other 27.5 percent of recipients receive Medicaid services through the fee-for-service (FFS) delivery model, where providers contract directly with the AHCA to render services, billing and receiving reimbursement directly from the AHCA; Florida Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[6] Florida Agency for Health Care Administration, *Florida Statewide Medicaid Enrollment Report As of February 28, 2025 (including Medikids Population), available at* https://ahca.myflorida.com/content/download/26230/file/ENR_202502.xls (last visited Mar. 27, 2025).
[7] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited Mar. 27, 2025).
[8] Florida Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[9] *Id.*
[10] Florida Agency for Health Care Administration, *Senate Bill 1060* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[11] *Supra* note 8.

- Transportation to medical services;
- Nursing facility services; and
- Other service benefits, including, but not limited to, medical equipment and supplies, therapies, and home health services.

The AHCA contracts with LTC plans in each region to provide LTC services, including all home and community-based waiver services, through their provider networks. Currently, all of the LTC plans contracted with the AHCA are also contracted to provide MMA services, streamlining care with a more comprehensive enrollment approach where a Medicaid recipient can enroll with one plan for all services.[12]

The SMMC program includes the following regions:[13]

- Region A, which consists of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties.
- Region B, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia counties.
- Region C, which consists of Pasco and Pinellas counties.
- Region D, which consists of Hardee, Highlands, Hillsborough, Manatee, and Polk counties.
- Region E, which consists of Brevard, Orange, Osceola, and Seminole counties.
- Region F, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota counties.
- Region G, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties.
- Region H, which consists of Broward County.
- Region I, which consists of Miami-Dade and Monroe counties.

Provider Networks

A provider network is a list of doctors, hospitals, and other health care providers that a plan contracts with to provide medical care to its enrollees. These providers are commonly known as participating providers, and a provider that is not contracted with the plan is called a nonparticipating provider.[14]

SMMC Plan Accountability – Network Access & Adequacy

The SMMC plans must adhere to all requirements as specified in their contract with the AHCA, including requirements to enter into provider agreements with a sufficient number of providers to deliver all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided with reasonable promptness, including the utilization of

[12] *Id*.
[13] *Section* 409.966(2), F.S.
[14] U.S. Department of Health & Human Services, Health Insurance Marketplace, *What You Should Know About Provider Networks, available at* https://www.cms.gov/marketplace/outreach-and-education/what-you-should-know-provider-networks.pdf (last visited Mar. 27, 2025).

nonparticipating providers.[15] If the managed care plan declines to include individual or group providers in its provider network, the plan is required to give written notice to the affected provider(s) of the reason for its decision.[16,17]

Prior to implementation of SMMC 3.0 on February 1, 2025, the AHCA indicated that the network sufficiency of each plan was assessed to ensure an adequate number of available providers exists within the plans' provider networks. Managed care plans are contractually required to develop a printed and online (electronic) provider network directory to assist enrollees in selecting from qualified providers. The plans must update their online provider database at least weekly and provide printed copies of provider directories to enrollees upon request, at no charge. The plans must have procedures to inform current enrollees and potential enrollees, upon request, of any changes to service delivery and/or provider network.

On a regional basis, managed care plans must notify the AHCA within seven business days of a decrease in the total number of primary care providers by more than five percent. Moreover, the plans are required to submit an Annual Network Development Plan[18] that includes a description or explanation of the current status of their network for each service covered.[19]

Additionally, the plans are required to submit weekly Provider Network Verification (PNV) files,[20] which include information on each plan's provider network. The AHCA monitors the PNV files to ensure contractually required provider network standards are being met. If a plan is not compliant with these standards, the AHCA has actions available through its contracts that can be applied, including liquidated damages.[21] Managed care plans online and printed provider directories are monitored monthly for accuracy and completeness. Furthermore, the AHCA monitors the networks to ensure that contractual provider-specific geographic access (time and distance) standards for enrollees in urban or rural counties are maintained.[22]

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[15] 42 C.F.R. § 438.206(b)(4)
[16] 42 C.F.R. § 438.12(a)(1)
[17] *Supra* note 8.
[18] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Attachment II – Core Contract Provisions* (Feb. 2025), Page 236 of 267, *available at* https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf (last visited Mar. 27, 2025).
[19] *Supra* note 8.
[20] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Attachment II – Core Contract Provisions* (Feb. 2025), Page 234 of 267, *available at* https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf (last visited Mar. 27, 2025).
[21] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Attachment II – Core Contract Provisions* (Feb. 2025), Page 201 of 267, *available at* https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf (last visited Mar. 27, 2025).
[22] *Supra* note 8.

The required regional provider ratios and network adequacy standards, as well as the time and distance standards for covered services, providers, and facilities, are contained within the contracts between the AHCA and the Medicaid managed care plans.[23,24,25]

Currently, at least 50 percent of primary care providers participating in a plan provider network in regions A, B, E, G, H, and I must offer after hours[26] appointment availability to Medicaid enrollees; however, regions C and D require at least 45 percent, and region F requires at least 40 percent.[27]

III. Effect of Proposed Changes:

The bill amends s. 409.967, F.S., to require the AHCA to establish specific standards to ensure enrollees have access to network providers during state holidays and outside regular business hours. At least 50 percent of primary care providers participating in a plan provider network must offer appointment availability to Medicaid enrollees outside regular business hours.

The bill defines the term "outside regular business hours" to mean Monday through Friday between 5 p.m., and 8 a.m., local time and all-day Saturday and Sunday.

The bill provides an effective date of July 1, 2025.

[23] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-A – Managed Medical Assistance Program* (Feb. 2025), Pages 55-58, 60-61, *available at* https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf (last visited Mar. 27, 2025).
[24] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-A – Managed Medical Assistance Program* (Feb. 2025), Pages 70-72, *available at* https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf (last visited Mar. 27, 2025).
[25] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-B – Long-Term Care (LTC) Program* (Feb. 2025), Pages 32-34, *available at* https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf (last visited Mar. 27, 2025).
[26] The AHCA defines "after hours" in its health plan contracts to mean the hours between 5:00 p.m., and 8:00 a.m., local time, Monday through Friday inclusive, and all-day Saturday and Sunday. State holidays are also included. *See* Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Attachment II – Core Contract Provisions* (Feb. 2025), Page 238, *available at* https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf (last visited Apr. 2, 2025).
[27] *Supra* note 24.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.967 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:
The committee substitute:

- Removes the underlying bill's amendments to Medicaid managed care plan accountability statutes.
- Requires the AHCA to establish standards to ensure Medicaid enrollees have access to network providers during state holidays and outside regular business hours.
- Requires Medicaid managed care plans to ensure at least 50 percent of primary care providers participating in their network offer appointment availability to Medicaid enrollees outside regular business hours.
- Defines the term "outside regular business hours" to mean Monday through Friday between 5 p.m., and 8 a.m., local time and all-day Saturday and Sunday.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
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The Committee on Health Policy (Sharief) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem

931448

necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region.

2. The agency shall establish specific standards to ensure enrollees have access to network providers during state holidays and outside regular business hours. At least 50 percent of primary care providers participating in a plan provider network must offer appointment availability to Medicaid enrollees outside regular business hours. For the purposes of this subparagraph, the term "outside regular business hours" means Monday through Friday between 5 p.m. and 8 a.m. local time and all day Saturday and Sunday.

3. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy

931448

standards and to accept and display feedback from each provider's patients.

4. Each plan must ~~shall~~ submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

5. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

6.~~2.~~ Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

7.~~3.~~ Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

8.~~4.~~ Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter

931448

information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and follow-up ~~followup~~ on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 2. This act shall take effect July 1, 2025.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to Medicaid providers; amending s. 409.967, F.S.; requiring the Agency for Health Care Administration to include specified requirements in its contracts with Medicaid managed care plans; defining the term "outside regular business hours"; providing an effective date.

By Senator Sharief

35-00489-25 2025306__

A bill to be entitled

An act relating to managed care plan network access; amending s. 409.967, F.S.; requiring that the Agency for Health Care Administration include specified requirements in its contracts with Medicaid managed care plans; amending s. 409.975, F.S.; authorizing enrollees of Medicaid managed care plans to receive care from Medicaid providers not under contract with the plan under certain circumstances; requiring the plans to reimburse such providers at the applicable rates paid for such services under the plan; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

plan. Plans must allow enrollees to receive care from Medicaid providers not under contract with the plan if an enrollee is unable to receive care from a participating provider under the plan in a timely manner consistent with a reasonable access standard, as determined by agency rule, or there is another appropriate Medicaid provider in a location more geographically accessible to the enrollee's residence than those under the plan. The plan must reimburse the nonparticipating Medicaid providers for such services at the applicable Medicaid rate for such services under the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. Each plan must ~~shall~~ establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan must ~~shall~~ submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and

confirm that enrollees have access to behavioral health services.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to

the department is ~~shall be~~ the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and follow-up ~~followup~~ on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 2. Paragraph (f) is added to subsection (1) of section 409.975, Florida Statutes, to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(f) If an enrollee is unable to receive care from a participating provider under the managed care plan in a timely manner consistent with a reasonable access standard, as determined by agency rule, or there is another appropriate Medicaid provider in a location more geographically accessible to the enrollee's residence than those under the plan, an enrollee may receive such care from a Medicaid provider not under contract with the plan. Plans must reimburse a nonparticipating Medicaid provider for services rendered under this paragraph at the applicable Medicaid rate for such services

under the plan.

Section 3. This act shall take effect July 1, 2025.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 4, 2025

I respectfully request that **Senate Bill #306**, relating to Managed Care Plan Network Access, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Barbara Sharief
Florida Senate, District 35

File signed original with committee office

S-020 (03/2004)

Tab 9

The Florida Senate

APPEARANCE RECORD

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

4/1/2025
Meeting Date

Health Policy
Committee

SB 306
Bill Number or Topic

Amendment Barcode (if applicable)

Name David Mica, Jr.

Phone 8502229800

Email Davidm@fha.org

Address 306 E College Ave
Street

Tallahassee FL 32312
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Hospital Association

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

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

S-001 (08/10/2021)

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

The Florida Senate

APPEARANCE RECORD

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

04/01/2025
Meeting Date

Health Policy
Committee

SB 306
Bill Number or Topic

Amendment Barcode (if applicable)

Name Edda Fernandez

Phone 954-850-7262

Email ifernandez@aarp.org

Address 215 Monroe Street 603
Street

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP

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

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S-001 (08/10/2021)

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1270
INTRODUCER:	Health policy Committee and Senator Collins
SUBJECT:	Department of Health
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith/Looke	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1270 revises statutes administered by the Department of Health (DOH), including provisions relating to medical marijuana regulation, health care practitioner licensure, patient rights, and public health mandates.

The bill reenacts ss. 381.00316(2)(g) and 381.00319(1)(e), F.S., and repeals section 9 of chapter 2023-43, L.O.F., to preserve the statutory definition of "messenger ribonucleic acid vaccine" (mRNA vaccine). These provisions collectively maintain statutory prohibitions against discrimination based on knowledge or belief of a person's status relating to vaccination with any mRNA vaccine , including by governmental entities, business establishments, and educational institutions.

The bill amends s. 381.026, F.S., to prohibit health care providers and facilities from discriminating against a patient based solely on vaccination status and affirms a patient's right to impartial access to treatment or accommodations regardless of vaccination status.

The bill amends ss. 381.986 and 381.988, F.S., to define "owner," "manager," and "employee" for purposes of background screening requirements applicable to medical marijuana treatment centers (MMTCs) and certified marijuana testing laboratories (CMTLs)respectively. The bill requires MMTCs to report any actual or attempted theft, diversion, or loss of marijuana to local law enforcement and to notify the DOH by email.

The bill amends s. 456.0145, F.S., to establish that reported conduct in the National Practitioner Data Bank does not automatically disqualify an applicant from licensure as a health care practitioner under Florida's Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act if the conduct would not constitute a violation of Florida law or rule. In such cases, the bill authorizes the applicable regulatory board, or the DOH if there is no board, to approve the application, approve it with restrictions or conditions, or deny it.

The bill amends ss. 458.315 and 459.0076, F.S., to revise criteria for the issuance of temporary certificates for practice in areas of critical need by allopathic and osteopathic physician assistants. Under the bill, such temporary certificates are limited to physician assistants who are licensed in a U.S. state or the District of Columbia, thereby excluding those licensed only in U.S. territories.

The bill amends s. 486.112, F.S., to correct one material deviation and conform provisions of the Physical Therapy Licensure Compact the model language by defining the term "party state."

The bill amends s. 766.1115, F.S., to add dental hygiene students to the list of persons eligible for sovereign immunity when providing services to low-income individuals through qualified programs under the Access to Health Care Act.

The bill provides an effective date of July 1, 2025, except as otherwise expressly provided for provisions ensuring continuity of the statutory definition of "messenger ribonucleic acid vaccine," which shall take effect upon this act becoming a law and shall operate retroactively if this bill is enrolled but not yet enacted by that date.

II. Present Situation:

Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act

The MOBILE Act, codified in s. 456.0145, F.S., establishes a pathway for expedited licensure of health care professionals who are licensed in good standing in another state. The MOBILE Act was designed to facilitate workforce mobility and expand access to care by allowing eligible out-of-state practitioners to obtain licensure in Florida without undergoing traditional initial licensure requirements, such as additional examinations or coursework.

Under current law, applicants must have actively practiced their profession for the three years immediately preceding application. An applicant is ineligible for licensure under the MOBILE Act if he or she has a pending complaint or investigation in another jurisdiction, has been convicted or pled to an offense related to health care practice, has had a license revoked, suspended, or surrendered in another state, or has been reported to the National Practitioner Data Bank unless successfully removed through appeal.

As of January 6, 2025, MQA has received 3,263 MOBILE applications and issued 769 licenses.[1]

[1] Department of Health, Senate Bill 1270 *Legislative Analysis* (Mar. 11, 2025) (on file with the Senate Committee on Health Policy).

The Florida Department of Health (DOH)

The DOH is the state's primary public health agency, responsible for safeguarding the health and well-being of residents and visitors. Established in 1996, the DOH operates under the leadership of the State Surgeon General and encompasses various divisions, including Administration, Emergency Preparedness and Community Support, Disease Control and Health Protection, Community Health Promotion, and Medical Quality Assurance (MQA).[2] DOH comprises a state health office (central office) in Tallahassee, with statewide responsibilities; Florida's 67 county health departments (CHD); 8 Children's Medical Services (CMS) area offices; 12 Medical Quality Assurance (MQA) regional offices; nine Disability Determinations regional offices; and three public health laboratories.[3]

The Division of Medical Quality Assurance (MQA) within the DOH has general regulatory authority over health care practitioners. The MQA works in conjunction with 22 regulatory boards and four councils to license and regulate over 1.5 million health care practitioners.[4] Professions are generally regulated by individual practice acts and by ch. 456, F.S., which provides regulatory and licensure authority for the MQA.

Temporary Certificates for Practice in Areas of Critical Need

Both the BOM and the BOOM may issue temporary certificates to practice in areas of critical need to allopathic or osteopathic physicians and to allopathic and osteopathic physician assistants who agree to practice in those areas. An applicant for a temporary certificate must:[5]

- Be actively licensed to practice in any jurisdiction of the U.S.;
- Be employed by, or practice in, a county health department, correctional facility, Department of Veterans' Affairs clinic, federally-funded community health care center, or any other agency or institution designated by the State Surgeon General and provides health care to underserved populations; or
- Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the Surgeon General.

The BOM and the BOOM are authorized to administer an abbreviated oral examination to determine a physician's or physician assistant's competency. A written examination is not required.[6] The boards may deny the application, issue the temporary certificate with reasonable restrictions, or require the applicant to meet any reasonable conditions of the BOM or BOOM prior to issuing the temporary certificate if it has been more than three years since the applicant has actively practiced and the respective board determines the applicant lacks clinical competency, adequate skills, necessary medical knowledge, or sufficient clinical decision-making.[7]

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[2] Section 20.42, F.S.
[3] Florida Department of Health, about the Florida Department of Health, *available at* https://www.floridahealth.gov/about/index.html (last visited Mar. 29, 2025).
[4] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan: Fiscal Year 2023–2024*, *available at* https://mqawebteam.com/annualreports/2324/8/ (last visited Mar. 29, 2025).
[5] Sections 458.315, and 459.0076, F.S.
[6] *Id.*
[7] Sections 458.315(3)(b) and 459.0076(3)(b), F.S.

Physician fees for the temporary certificate for practice in areas of critical need include a $300 application fee and $429 initial licensure fee; however, these fees may be waived if the individual is not compensated for his or her practice.[8] The temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.[9] However, the boards must review the temporary certificate holder at least annually to ensure that he or she is in compliance with the practice act and rules adopted thereunder.[10] A board may revoke or restrict the temporary certificate for practice in areas of critical need if noncompliance is found.[11]

COVID-19 Vaccine and Testing Mandate Prohibitions

In 2023, CS/SB 252 was enacted to prohibit a business entity,[12] governmental entity,[13] or educational institution[14] from requiring any person to provide any documentation certifying vaccination with listed vaccines or postinfection recovery from COVID-19, or requiring a COVID-19 test, in order to gain access, entry upon, or service from entity or institution.

The 2023 bill, now codified in ss. 381.00316 and 381.00319, F.S., applies to the following vaccines:

- "COVID-19 vaccine" means a preparation designed to stimulate the human body's immune response against COVID-19.
- "Emergency use authorization vaccine" means any vaccine that is authorized for emergency use under 21 U.S.C. 360bbb-3(a)(1) and qualifies as an unapproved product under 21 U.S.C. 360bbb-3(a)(2)(A).
- "Messenger ribonucleic acid vaccine" means any vaccine that uses laboratory-produced messenger ribonucleic acid to trigger the human body's immune system to generate an immune response.

Those statutes prohibit:

- Requiring such documentation or testing as a condition of contracting, hiring, promotion, or continued employment;
- Using a knowledge or belief of a person's vaccination with any of the listed vaccines or COVID-19 postinfection status, or a person's failure to take a COVID-19 test, to:
  - Refuse to hire, or discharge, the person;
  - Deprive or attempt to deprive the person of employment opportunities;
  - Adversely affect the person's status as an employee or as an applicant; or
  - Otherwise discriminate against the person.

[8] Fla. Admin. Code Rs. 64B8-3.003, and 64B15-10.002 (2025).
[9] Sections 458.315(3), and 459.0076(3), F.S.
[10] Sections 458.315(3)(c), and 459.0076(3)(c), F.S.
[11] *Id.*
[12] "Business entity" has the same meaning as in s. 606.03, F.S., and also includes a charitable organization as defined in s. 496.404, a corporation not for profit as defined in s. 617.01401, a private club, or any other business operating in this state.
[13] "Governmental entity" means the state or any political subdivision thereof, including the Executive, Legislative, and Judicial branches of government; the independent establishments of the state, counties, municipalities, districts, authorities, boards, or commissions; or any agencies that are subject to chapter 286, F.S.
[14] "Educational institution" means a public or private school, including a preschool, elementary school, middle school, junior high school, secondary school, career center, or postsecondary school.

Current law also provides that if a governmental entity fails to comply with the above provisions, an employee terminated based on such noncompliance is eligible for reemployment assistance under ch. 443, F.S., in addition to any other remedies available for such violation.

Additionally, for matters related to any vaccine other than a defined vaccine, a defined entity or institution must provide for reasonable religious and medical accommodations in compliance with federal law.

The definitions for "messenger ribonucleic acid vaccine" in ss. 381.00316 and 381.00319, F.S., will automatically expire on June 1, 2025, effectively eliminating the prohibitions relating to that type of vaccine on that date.

Messenger Ribonucleic Acid (mRNA) Vaccines

Messenger RNA is a molecule that contains the instructions or recipe that directs cells in the human body to make a protein using their natural machinery. To enter cells smoothly, mRNA travels within a protective bubble called a Lipid Nanoparticle. Once inside, mRNA causes cells to read the mRNA as a set of instructions, building proteins that match parts of the pathogen called antigens. The immune system sees these foreign antigens as invaders, dispatching defenders called antibodies and T-cells, and training the immune system for potential future attacks. So, if and when the real virus comes along, the body might recognize it, sounding the alarm to help defend against infection and illness.

Though many people first became aware of mRNA technology because of COVID-19 vaccines, the technology is not new to the scientific community. For decades, scientists have studied mRNA, looking for ways to unlock its potential to prevent and treat disease. While the mechanism of action for mRNA technology is relatively simple, researchers have worked for years to develop technologies to allow mRNA to work in the real world.[15]

Current research is ongoing for mRNA vaccines for various infectious diseases, including HIV, Hepatitis C, Influenza, Malaria, and Tuberculosis. Additionally, researchers are working on mRNA vaccines for cancer and genetic diseases as well as treatments for food an environmental allergies.[16]

Florida Patient's Bill of Rights and Responsibilities

The Patient's Bill of Rights and Responsibilities, codified in s. 381.026, F.S., was created for the purpose of promoting better communication among patients and health care providers. The Legislature intends for the bill of rights to give patients an understanding of their rights and responsibilities to enable them to make informed decisions concerning their health.

[15] Pfizer, *Harnessing the Potential of mRNA, available at* https://www.pfizer.com/science/innovation/mrna-technology, (last visited Mar. 30, 2025).
[16] Penn Medicine, *The Future of mRNA Vaccines, available at* https://www.pennmedicine.org/mrna, (last visited Mar. 30, 2025).

The Patient's Bill of Rights and Responsibilities applies to health care facilities licensed under ch. 395, F.S., (hospitals, ambulatory surgical centers, and mobile surgical facilities), physicians licensed under chs. 458, 459, and 461, F.S., (allopathic, osteopathic, and podiatric physicians), and advanced practice registered nurses licensed under ch. 464, F.S.

Section 381.0261(1), F.S., requires the Department of Health (DOH) to provide a summary of the Patient's Bill of Rights on its website. The summary is codified in subsection (6) of that section. Subsection (6) also requires that health care facilities and health care providers provide a patient with a summary of these rights if the patient requests a copy.

Enforcement[17]

The Agency for Health Care Administration (AHCA) may impose an administrative fine against a health care facility when a health care facility fails to make the summary of rights available to its patients. For a first unintentional violation, the health care facility would not receive an administrative fine but would be subject to corrective action. The AHCA may impose a fine against a health care facility of up to $5,000 for unintentional violations and a fine of up to $25,000 for willful and intentional violations.

Regulatory boards may fine physicians when they fail to make the summary of rights available to their patients. For initial unintentional violations, a health care provider would not receive an administrative fine but would be subject to corrective action. A regulatory board or DOH may impose a fine of up to $100 against a health care provider for unintentional violations and a fine of up to $500 for willful violations.

Sovereign Immunity for Charitable Care

Section 766.1115, F.S., also known as the "Access to Health Care Act," provides protections against liability for health care providers who offer free quality medical services to underserved populations in Florida. The act provides that a health care provider that executes a contract with a governmental contractor[18] to provide health care services is considered an agent of the state for sovereign immunity purposes when acting under the scope of duties under the contract and may not be named as a defendant in any action arising out of medical care or treatment provided under the contracts entered into.

For the purposes of the Access to Health Care Act, a health care provider includes:

- A birth center.
- An ambulatory surgical center.
- A hospital.
- A medical doctor, osteopathic physician, or PA.
- A chiropractic physician.
- A podiatric physician.
- A registered nurse, nurse midwife, licensed practical nurse (LPN), or APRN or any facility which employs nurses to supply all or part of the care delivered.

[17] Section 381.0261(4) and (5), F.S.

[18] "Governmental contractor" is defined as the DOH, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.

- A midwife.
- A health maintenance organization.
- A health care professional association and its employees or a corporate medical group and its employees.
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
- A dentist or dental hygienist.
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.[19]
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as a physician or physician assistant, osteopathic physician or osteopathic physician assistant, chiropractic physician, podiatric physician, registered nurse, midwife, licensed practical nurse, or advanced practice registered nurse licensed, or midwife.

MMTC and CMTL Requirements

Background Screening Requirements

Because MMTCs and CMTLs handle medical marijuana, they are required to ensure that all owners, managers, and employees of the MMTC or CMTL have passed a level II background screening pursuant to the requirements specified in ss. 381.986(9) and 381.988(1)(d), F.S., respectively. In addition to the standard requirements for a Level II background screening, both sections also specify that any person who has an arrest awaiting final disposition for, has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to an offense under chs. 837,[20] 895,[21] or 896,[22] F.S., or similar law of another jurisdiction. Current law also prohibits exemptions from disqualification for the purposes of owning, managing, or being employed by a MMTC or CMTL.

FBI Requirements for MMTC and CMTL Background Screening Statutes

According to the DOH, background screenings are conducted using information systems controlled by the Federal Bureau of Investigation (FBI). Through the Florida Department of Law Enforcement (FDLE), the FBI has communicated that the department may not use the FBI's background check system to perform this regulatory requirement for certain categories of CMTL personnel until the DOH defines the terms "owner," "manager," and "employee" in statute, rather than rule. The FBI's basis for the need to define said terms in statute is that the terms fail to comply with Pub. L. 92-544.[23] Failure to update statutory language could result in loss of

[19] "Low-Income" is defined as A person who is Medicaid-eligible under Florida law; a person who is without health insurance and whose family income does not exceed 300 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.
[20] Related to perjury.
[21] Related to racketeering and illegal debts.
[22] Related to illegal financial transactions.
[23] For more info *see* https://www.fbi.gov/how-we-can-help-you/more-fbi-services-and-information/public-law-92-544, (last visited Mar. 28, 2025).

access to background screening tools necessary to perform background screenings required by ss. 381.986 and 381.988, F.S. The DOH has been given a grace period to effectuate these changes through July 1, 2026.[24]

Diversion Reporting Requirements

Section 381.986(8)(f)10, F.S., requires MMTCs to report to local law enforcement within 24 hours after the MMTC is notified of or becomes aware of theft, diversion, or loss of marijuana. Current law does not require the MMTC to report attempted theft, diversion, or loss of marijuana nor does it require the MMTC to notify the DOH of either attempted or actual theft, diversion, or loss of marijuana.

III. Effect of Proposed Changes:

Section 1 of the bill reenacts s. 381.00316(2)(g), F.S., to preserve the statutory definition of "messenger ribonucleic acid vaccine."[25] This reenactment maintains the operative provisions of s. 381.00316, F.S., which prohibits discrimination by governmental and business entities based on a person's vaccination status, including such status relating to an mRNA vaccine, beyond the scheduled repeal date of June 1, 2025, and provides for retroactive application to June 1, 2025, if this bill is enrolled, but not enacted before that date.

Section 2 of the bill reenacts s. 381.00319(1)(e), F.S., which cross-references the definition of "messenger ribonucleic acid vaccine" in s. 381.00316, F.S., as applied to educational institutions. This reenactment maintains the operative provisions of s. 381.00319, F.S., to ensure continuity of statutory prohibitions on COVID-19 testing, mask, and vaccination mandates for schools and universities, beyond the scheduled repeal date of June 1, 2025, and provides for retroactive application to June 1, 2025, if this bill is enrolled, but not enacted before that date.

Section 3 of the bill repeals section 9 of chapter 2023-43, L.O.F., which, but for its own repeal, is scheduled to repeal the statutory definition of "messenger ribonucleic acid vaccine" in both s. 381.00316(2)(g) and s. 381.00319(1)(e), F.S., on June 1, 2025. This repeal would ensure the continued enforceability of the statutory definition and, like with sections 1 and 2 of the bill, this section also provides for retroactive application to June 1, 2025, if this bill is enrolled, but not enacted before that date.

Section 4 of the bill amends s. 381.026, F.S., the Florida Patient's Bill of Rights and Responsibilities, to prohibit a health care provider[26] or health care facility[27] from discriminating against a patient based solely upon the patient's vaccination status.

It also establishes that a patient has the right to impartial access to medical treatment or accommodations, regardless of vaccination status.

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[24] *Supra* note 1.
[25] "Messenger ribonucleic acid vaccine" means any vaccine that uses laboratory-produced messenger ribonucleic acid to trigger the human body's immune system to generate an immune response.
[26] "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a podiatric physician licensed under chapter 461, or an advanced practice registered nurse registered under s. 464.0123. Section 381.026(2)(c), F.S.
[27] "Health care facility" means a facility licensed under chapter 395. Section 381.026(2)(b), F.S.

Section 5 of the bill amends s. 381.986, F.S., to define, related to background screening requirements for MMTCs, the terms:

- "Owner" to mean any person who owns or controls a five percent or greater share of interests of the applicant or MMTC which include beneficial or voting rights to interests. In the event that one person owns a beneficial right to interests and another person holds the voting rights with respect to such interests, then in such case, both are considered the owner of such interests.
- "Manager" to mean any person with the authority to exercise or contribute to the operational control, direction, or management of an applicant or MMTC or who has authority to supervise any employee of an applicant or MMTC. This includes officers and board members.
- "Employee" to mean any person who is employed by a MMTC licensee in any capacity, including those whose duties involve any aspect of the cultivation, processing, transportation, or dispensing of marijuana. This requirement applies to all employees, regardless of the compensation received.

The bill also requires MMTCs to report any actual or attempted theft, diversion, or loss of marijuana to local law enforcement and notify the DOH of the actual or attempted theft, diversion, or loss of marijuana by email.

Section 6 of the bill amends s. 381.988, F.S., to define, related to background screening requirements for CMTLs, the terms:

- "Owner" to mean any person who owns or controls a five percent or greater share of interests of the applicant or CMTL which include beneficial or voting rights to interests. In the event that one person owns a beneficial right to interests and another person holds the voting rights with respect to such interests, then in such case, both are considered the owner of such interests.
- "Manager" to mean any person with authority to exercise or contribute to the operational control, direction, or management of an applicant or CMTL or who has authority to supervise any employee of an applicant or a CMTL. This includes officers and board members.
- "Employee" to mean any person whose duties or activities involve any aspect of regulatory compliance testing or research and development testing of marijuana for a CMTL, regardless of whether such person is compensated for his or her work.

Section 7 of the bill amends s. 456.0145, F.S., to provide that an applicant who has had his or her conduct reported in the National Practitioner Data Bank may be eligible for licensure under the MOBILE (Mobile Opportunity by Interstate Licensure Endorsement) Act if the reported conduct would not constitute a violation of Florida law or rule. If the reported conduct would not constitute a violation of any law or rule in Florida, the applicable board, or the DOH, if there is no board, may:

- Approve the application;
- Approve the application with restrictions on the licensee's scope of practice;
- Approve the application for a probationary period subject to conditions; or
- Deny the application.

Sections 8 and 9 of the bill amend ss. 458.315 and 459.0076, F.S., to revise the standards for which the Board of Medicine and Osteopathic Medicine, respectively, may issue temporary certificates to allopathic and osteopathic physician assistants (PAs) for practice in areas of critical need, limiting these temporary certificates to PAs who are licensed to practice in any state of the United States or the District of Columbia. In effect, this would exclude PAs who are licensed in other jurisdictions of the U.S., such as those licensed in U.S. territories such as Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

Section 10 of the bill amends s. 486.112, F.S., to conform provisions of the Physical Therapy Licensure Compact to cure one material deviation by conforming to the compact model language relating to the term "party state."

Section 11 of the bill amends s. 766.1115, F.S., to add dental and dental hygiene students to the list of persons eligible for sovereign immunity under the Access to Health Care Act.

Section 12 provides an effective date of July 1, 2025, except as otherwise expressly provided in sections 1, 2, and 3 of the bill which shall take effect upon this act becoming a law and shall operate retroactively if this bill is enrolled but not yet enacted by that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Section 6 of Article III of the State Constitution, requires every law to "embrace but one subject and matter properly connected therewith, and the subject shall be briefly expressed in the title." The subject as expressed in the title circumscribes the one subject to which the act must relate. CS/SB 1270 is titled "An act relating to the Department of Health." Section 4 of the bill amends the Florida Patient's Bill of Rights and Responsibilities to prohibit a health care facility licensed under ch. 395, F.S., including hospitals, ambulatory surgical centers, and mobile surgical facilities, from discriminating against a patient based solely upon the patient's vaccination status. These health care facilities are regulated by the Agency for Health Care Administration and not the

department. It is unclear whether a court would find that this section of the bill is "properly connected therewith" an Act relating to the Department of Health.

Similarly, section 11 of the bill amends the Access to Health Care Act, which applies to a "health care provider" that executes a contract with a governmental contractor. The definition of the term "health care provider" as written in s. 766.115(3)(d), F.S., both in current law and as amended by this bill, includes specified licensed practitioners regulated by the department, as well as numerous other entities, many of which are not regulated by the department. Some of the entities, including students preparing for licensure as specified health care practitioners, aren't regulated by the state at all. The bill specifically adds dental and dental hygiene students to the list of persons eligible for sovereign immunity. It is unclear whether a court would find that the addition made by the bill relates to the Department of Health.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.026, 381.986, 381.988, 456.0145, 458.315, 459.0076, 486.112, and 766.1115.

This bill reenacts the following sections of the Florida Statutes: 381.00316 and 381.00319.

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:

The CS expands the Patient's Bill of Rights and Responsibilities to prohibit discrimination based on vaccination status. The CS revises standards for issuing temporary certificates to PAs for practice in areas of critical need by excluding PAs who are not licensed by a U.S. state or the District of Columbia. The CS also adds dental and dental hygiene students to the list of persons eligible for sovereign immunity under the Access to Health Care Act.

The CS removes provisions in the underlying bill that would have eliminated certain regulatory boards and councils. It also removes a provision that would have required the department to conduct a study on the efficiency of its boards and councils. Additionally, the amendment preserves the statutorily required three-year duration of active practice for applicants under the Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.

The CS revises the effective date of the bill for bill sections 1, 2, and 3, to ensure the continuity of the statutory definition of "messenger ribonucleic acid vaccine," which shall take effect upon this act becoming a law and shall operate retroactively if this bill is enrolled but not yet enacted by that date.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

275506

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
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	.	

The Committee on Health Policy (Collins) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Effective upon becoming a law, or, if this act fails to become a law until after June 1, 2025, operating retroactively to June 1, 2025, notwithstanding the scheduled repeal in section 9 of chapter 2023-43, Laws of Florida, paragraph (g) of subsection (2) of section 381.00316, Florida Statutes, is reenacted to read:

275506

381.00316 Discrimination by governmental and business entities based on health care choices; prohibition.—

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

(g) "Messenger ribonucleic acid vaccine" means any vaccine that uses laboratory-produced messenger ribonucleic acid to trigger the human body's immune system to generate an immune response.

Section 2. Effective upon becoming a law, or, if this act fails to become a law until after June 1, 2025, operating retroactively to June 1, 2025, notwithstanding the scheduled repeal in section 9 of chapter 2023-43, Laws of Florida, paragraph (e) of subsection (1) of section 381.00319, Florida Statutes, is reenacted to read:

381.00319 Prohibition on mask mandates and vaccination and testing mandates for educational institutions.—

(1) For purposes of this section, the term:

(e) "Messenger ribonucleic acid vaccine" has the same meaning as in s. 381.00316.

Section 3. Effective upon becoming a law, or, if this act fails to become a law until after June 1, 2025, operating retroactively to June 1, 2025, section 9 of chapter 2023-43, Laws of Florida, is repealed.

Section 4. Paragraphs (b) and (d) of subsection (4) and subsection (6) of section 381.026, Florida Statutes, are amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(4) RIGHTS OF PATIENTS.—Each health care facility or provider shall observe the following standards:



(b) *Information.*—

1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a



grievance.

7. A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

8. A health care provider or health care facility shall respect a patient's right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care provider or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety, or safety of others, may make such a verbal or written inquiry.

9. A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient, or the presence of a firearm in the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.

10. A health care provider or health care facility may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.

11. A health care provider or health care facility shall



respect a patient's legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about firearm ownership during an examination.

12. A health care provider or health care facility may not discriminate against a patient based solely upon the patient's vaccination status.

(d) *Access to health care.*—

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, vaccination status, or source of payment.

2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.

3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of s. 456.41.

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.—Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient, in writing, a statement of the rights and responsibilities of patients, including the following:

SUMMARY OF THE FLORIDA PATIENT'S BILL
OF RIGHTS AND RESPONSIBILITIES


275506

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so



would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, vaccination



status, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care



provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Section 5. Paragraphs (b), (e), and (f) of subsection (8) of section 381.986, Florida Statutes, are amended to read:

381.986 Medical use of marijuana.—

(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(b) An applicant for licensure as a medical marijuana treatment center must ~~shall~~ apply to the department on a form prescribed by the department and adopted in rule. The department shall adopt rules pursuant to ss. 120.536(1) and 120.54 establishing a procedure for the issuance and biennial renewal of licenses, including initial application and biennial renewal fees sufficient to cover the costs of implementing and administering this section, and establishing supplemental licensure fees for payment beginning May 1, 2018, sufficient to cover the costs of administering ss. 381.989 and 1004.4351. The

275506

department shall identify applicants with strong diversity plans reflecting this state's commitment to diversity and implement training programs and other educational programs to enable minority persons and minority business enterprises, as defined in s. 288.703, and veteran business enterprises, as defined in s. 295.187, to compete for medical marijuana treatment center licensure and contracts. Subject to the requirements in subparagraphs (a)2.-4., the department shall issue a license to an applicant if the applicant meets the requirements of this section and pays the initial application fee. The department shall renew the licensure of a medical marijuana treatment center biennially if the licensee meets the requirements of this section and pays the biennial renewal fee. However, the department may not renew the license of a medical marijuana treatment center that has not begun to cultivate, process, and dispense marijuana by the date that the medical marijuana treatment center is required to renew its license. An individual may not be an applicant, owner, officer, board member, or manager on more than one application for licensure as a medical marijuana treatment center. An individual or entity may not be awarded more than one license as a medical marijuana treatment center. An applicant for licensure as a medical marijuana treatment center must demonstrate:

1. That, for the 5 consecutive years before submitting the application, the applicant has been registered to do business in this ~~the~~ state.

2. Possession of a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131.


275506

3. The technical and technological ability to cultivate and produce marijuana, including, but not limited to, low-THC cannabis.

4. The ability to secure the premises, resources, and personnel necessary to operate as a medical marijuana treatment center.

5. The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.

6. An infrastructure reasonably located to dispense marijuana to registered qualified patients statewide or regionally as determined by the department.

7. The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financial statements to the department.

a. Upon approval, the applicant must post a $5 million performance bond issued by an authorized surety insurance company rated in one of the three highest rating categories by a nationally recognized rating service. However, a medical marijuana treatment center serving at least 1,000 qualified patients is only required to maintain a $2 million performance bond.

b. In lieu of the performance bond required under sub-subparagraph a., the applicant may provide an irrevocable letter of credit payable to the department or provide cash to the department. If provided with cash under this sub-subparagraph, the department must ~~shall~~ deposit the cash in the Grants and Donations Trust Fund within the Department of Health, subject to


275506

the same conditions as the bond regarding requirements for the applicant to forfeit ownership of the funds. If the funds deposited under this sub-subparagraph generate interest, the amount of that interest must ~~shall~~ be used by the department for the administration of this section.

8. That all owners~~, officers, board members,~~ and managers have passed a background screening pursuant to subsection (9). As used in this subparagraph, the term:

a. "Manager" means any person with the authority to exercise or contribute to the operational control, direction, or management of an applicant or a medical marijuana treatment center or who has authority to supervise any employee of an applicant or a medical marijuana treatment center. This includes officers and board members.

b. "Owner" means any person who owns or controls a 5 percent or greater share of interests of the applicant or a medical marijuana treatment center which include beneficial or voting rights to interests. In the event that one person owns a beneficial right to interests and another person holds the voting rights with respect to such interests, then in such case, both are considered the owner of such interests.

9. The employment of a medical director to supervise the activities of the medical marijuana treatment center.

10. A diversity plan that promotes and ensures the involvement of minority persons and minority business enterprises, as defined in s. 288.703, or veteran business enterprises, as defined in s. 295.187, in ownership, management, and employment. An applicant for licensure renewal must show the effectiveness of the diversity plan by including the following

275506

with his or her application for renewal:

a. Representation of minority persons and veterans in the medical marijuana treatment center's workforce;

b. Efforts to recruit minority persons and veterans for employment; and

c. A record of contracts for services with minority business enterprises and veteran business enterprises.

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



reasonably determine will not be a lower standard than the specific representation in the application. A variance may not be granted from the requirements in subparagraph 2. and subparagraphs (b)1. and 2.

1. A licensed medical marijuana treatment center may transfer ownership to an individual or entity who meets the requirements of this section. A publicly traded corporation or publicly traded company that meets the requirements of this section is not precluded from ownership of a medical marijuana treatment center. To accommodate a change in ownership:

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

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

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

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

e. Within 30 days after the receipt of a complete



388 application, the department shall approve or deny the
389 application.
390 2. A medical marijuana treatment center, and any individual
391 or entity who directly or indirectly owns, controls, or holds
392 with power to vote 5 percent or more of the voting shares of a
393 medical marijuana treatment center, may not acquire direct or
394 indirect ownership or control of any voting shares or other form
395 of ownership of any other medical marijuana treatment center.
396 3. A medical marijuana treatment center may not enter into
397 any form of profit-sharing arrangement with the property owner
398 or lessor of any of its facilities where cultivation,
399 processing, storing, or dispensing of marijuana and marijuana
400 delivery devices occurs.
401 4. All employees of a medical marijuana treatment center
402 must be 21 years of age or older and have passed a background
403 screening pursuant to subsection (9). As used in this
404 subparagraph, the term "employee" means any person employed by a
405 medical marijuana treatment center licensee in any capacity,
406 including those whose duties involve any aspect of the
407 cultivation, processing, transportation, or dispensing of
408 marijuana. This requirement applies to all employees, regardless
409 of the compensation received.
410 5. Each medical marijuana treatment center must adopt and
411 enforce policies and procedures to ensure employees and
412 volunteers receive training on the legal requirements to
413 dispense marijuana to qualified patients.
414 6. When growing marijuana, a medical marijuana treatment
415 center:
416 a. May use pesticides determined by the department, after



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

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

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

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

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

8. A medical marijuana treatment center that produces edibles must hold a permit to operate as a food establishment pursuant to chapter 500, the Florida Food Safety Act, and must comply with all the requirements for food establishments pursuant to chapter 500 and any rules adopted thereunder. Edibles may not contain more than 200 milligrams of tetrahydrocannabinol, and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may <u>not</u> have a potency variance ~~of no~~ greater than 15 percent. Marijuana products, including edibles, may not be attractive to children; be manufactured in the shape of humans, cartoons, or animals; be manufactured in a form that bears any reasonable resemblance to products available for consumption as



commercially available candy; or contain any color additives. To discourage consumption of edibles by children, the department shall determine by rule any shapes, forms, and ingredients allowed and prohibited for edibles. Medical marijuana treatment centers may not begin processing or dispensing edibles until after the effective date of the rule. The department shall also adopt sanitation rules providing the standards and requirements for the storage, display, or dispensing of edibles.

9. Within 12 months after licensure, a medical marijuana treatment center must demonstrate to the department that all of its processing facilities have passed a Food Safety Good Manufacturing Practices, such as Global Food Safety Initiative or equivalent, inspection by a nationally accredited certifying body. A medical marijuana treatment center must immediately stop processing at any facility which fails to pass this inspection until it demonstrates to the department that such facility has met this requirement.

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

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

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

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



humans.

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

d. Test the processed marijuana using a medical marijuana testing laboratory before it is dispensed. Results must be verified and signed by two medical marijuana treatment center employees. Before dispensing, the medical marijuana treatment center must determine that the test results indicate that low-THC cannabis meets the definition of low-THC cannabis, the concentration of tetrahydrocannabinol meets the potency requirements of this section, the labeling of the concentration of tetrahydrocannabinol and cannabidiol is accurate, and all marijuana is safe for human consumption and free from contaminants that are unsafe for human consumption. The department shall determine by rule which contaminants must be tested for and the maximum levels of each contaminant which are safe for human consumption. The Department of Agriculture and Consumer Services shall assist the department in developing the testing requirements for contaminants that are unsafe for human consumption in edibles. The department shall also determine by rule the procedures for the treatment of marijuana that fails to meet the testing requirements of this section, s. 381.988, or department rule. The department may select samples of marijuana from a medical marijuana treatment center facility which shall

275506

be tested by the department to determine whether the marijuana meets the potency requirements of this section, is safe for human consumption, and is accurately labeled with the tetrahydrocannabinol and cannabidiol concentration or to verify the result of marijuana testing conducted by a marijuana testing laboratory. The department may also select samples of marijuana delivery devices from a medical marijuana treatment center to determine whether the marijuana delivery device is safe for use by qualified patients. A medical marijuana treatment center may not require payment from the department for the sample. A medical marijuana treatment center must recall marijuana, including all marijuana and marijuana products made from the same batch of marijuana, that fails to meet the potency requirements of this section, that is unsafe for human consumption, or for which the labeling of the tetrahydrocannabinol and cannabidiol concentration is inaccurate. The department shall adopt rules to establish marijuana potency variations of no greater than 15 percent using negotiated rulemaking pursuant to s. 120.54(2)(d) which accounts for, but is not limited to, time lapses between testing, testing methods, testing instruments, and types of marijuana sampled for testing. The department may not issue any recalls for product potency as it relates to product labeling before issuing a rule relating to potency variation standards. A medical marijuana treatment center must also recall all marijuana delivery devices determined to be unsafe for use by qualified patients. The medical marijuana treatment center must retain records of all testing and samples of each homogeneous batch of marijuana for at least 9 months. The medical marijuana treatment center must

275506

contract with a marijuana testing laboratory to perform audits on the medical marijuana treatment center's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the marijuana or low-THC cannabis meets the requirements of this section and that the marijuana or low-THC cannabis is safe for human consumption. A medical marijuana treatment center shall reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of such audits. A medical marijuana treatment center may use a laboratory that has not been certified by the department under s. 381.988 until such time as at least one laboratory holds the required certification, but in no event later than July 1, 2018.

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

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

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

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

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

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

(V) The name of the patient.

(VI) The product name, if applicable, and dosage form, including concentration of tetrahydrocannabinol and cannabidiol.


275506

The product name may not contain wording commonly associated with products that are attractive to children or which promote the recreational use of marijuana.

(VII) The recommended dose.

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

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

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

a. Clinical pharmacology.

b. Indications and use.

c. Dosage and administration.

d. Dosage forms and strengths.

e. Contraindications.

f. Warnings and precautions.

g. Adverse reactions.

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

14. The department shall adopt rules to regulate the types,



appearance, and labeling of marijuana delivery devices dispensed from a medical marijuana treatment center. The rules must require marijuana delivery devices to have an appearance consistent with medical use.

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

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

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

b. May not dispense more than a 70-day supply of marijuana within any 70-day period to a qualified patient or caregiver. May not dispense more than one 35-day supply of marijuana in a form for smoking within any 35-day period to a qualified patient or caregiver. A 35-day supply of marijuana in a form for smoking



may not exceed 2.5 ounces unless an exception to this amount is approved by the department pursuant to paragraph (4)(f).

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

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

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

f. May not dispense or sell any other type of cannabis, alcohol, or illicit drug-related product, including pipes or wrapping papers made with tobacco or hemp, other than a marijuana delivery device required for the medical use of marijuana and which is specified in a physician certification.

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

275506

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

(f) To ensure the safety and security of premises where the cultivation, processing, storing, or dispensing of marijuana occurs, and to maintain adequate controls against the diversion, theft, and loss of marijuana or marijuana delivery devices, a medical marijuana treatment center shall:

1.a. Maintain a fully operational security alarm system that secures all entry points and perimeter windows and is equipped with motion detectors; pressure switches; and duress, panic, and hold-up alarms; and

b. Maintain a video surveillance system that records continuously 24 hours a day and meets the following criteria:

(I) Cameras are fixed in a place that allows for the clear identification of persons and activities in controlled areas of the premises. Controlled areas include grow rooms, processing rooms, storage rooms, disposal rooms or areas, and point-of-sale rooms.

(II) Cameras are fixed in entrances and exits to the premises, which must ~~shall~~ record from both indoor and outdoor, or ingress and egress, vantage points.

(III) Recorded images must clearly and accurately display the time and date.

(IV) Retain video surveillance recordings for at least 45 days or longer upon the request of a law enforcement agency.

2. Ensure that the medical marijuana treatment center's outdoor premises have sufficient lighting from dusk until dawn.

3. Ensure that the indoor premises where dispensing occurs

275506

includes a waiting area with sufficient space and seating to accommodate qualified patients and caregivers and at least one private consultation area that is isolated from the waiting area and area where dispensing occurs. A medical marijuana treatment center may not display products or dispense marijuana or marijuana delivery devices in the waiting area.

4. Not dispense from its premises marijuana or a marijuana delivery device between the hours of 9 p.m. and 7 a.m., but may perform all other operations and deliver marijuana to qualified patients 24 hours a day.

5. Store marijuana in a secured, locked room or a vault.

6. Require at least two of its employees, or two employees of a security agency with whom it contracts, to be on the premises at all times where cultivation, processing, or storing of marijuana occurs.

7. Require each employee or contractor to wear a photo identification badge at all times while on the premises.

8. Require each visitor to wear a visitor pass at all times while on the premises.

9. Implement an alcohol and drug-free workplace policy.

10. Report to local law enforcement and notify the department through e-mail within 24 hours after the medical marijuana treatment center is notified or becomes aware of any actual or attempted ~~the~~ theft, diversion, or loss of marijuana.

Section 6. Paragraph (d) of subsection (1) of section 381.988, Florida Statutes, is amended to read:

381.988 Medical marijuana testing laboratories; marijuana tests conducted by a certified laboratory.—

(1) A person or entity seeking to be a certified marijuana



testing laboratory must:

(d) Require all employees, owners, and managers to submit to and pass a level 2 background screening pursuant to chapter 435. The department shall deny certification if the person or entity seeking certification has a disqualifying offense as provided in s. 435.04 or has an arrest awaiting final disposition for, has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in chapter 837, chapter 895, or chapter 896 or similar law of another jurisdiction. Exemptions from disqualification as provided under s. 435.07 do not apply to this paragraph.

1. As used in this paragraph, the term:

a. "Employee" means any person whose duties or activities involve any aspect of regulatory compliance testing or research and development testing of marijuana for a certified marijuana testing laboratory, regardless of whether such person is compensated for his or her work.

b. "Manager" means any person with authority to exercise or contribute to the operational control, direction, or management of an applicant or certified marijuana testing laboratory or who has authority to supervise any employee of an applicant or a certified marijuana testing laboratory. This includes officers and board members.

c. "Owner" means any person who owns or controls a 5 percent or greater share of interests of the applicant or a certified marijuana testing laboratory which include beneficial or voting rights to interests. In the event that one person owns a beneficial right to interests and another person holds the


275506

voting rights with respect to such interests, then in such case, both are considered the owner of such interests.

2. Such employees, owners, and managers must submit a full set of fingerprints to the department or to a vendor, entity, or agency authorized by s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing.

3.~~2.~~ Fees for state and federal fingerprint processing and retention must ~~shall~~ be borne by the certified marijuana testing laboratory. The state cost for fingerprint processing is ~~shall be~~ as provided in s. 943.053(3)(e) for records provided to persons or entities other than those specified as exceptions therein.

4.~~3.~~ Fingerprints submitted to the Department of Law Enforcement pursuant to this paragraph must ~~shall~~ be retained by the Department of Law Enforcement as provided in s. 943.05(2)(g) and (h) and, when the Department of Law Enforcement begins participation in the program, enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. Any arrest record identified must ~~shall~~ be reported to the department.

Section 7. Paragraph (c) of subsection (2) of section 456.0145, Florida Statutes, is amended to read:

456.0145 Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.—

(2) LICENSURE BY ENDORSEMENT.—

(c) A person is ineligible for a license under this section



if he or she:

1. Has a complaint, an allegation, or an investigation pending before a licensing entity in another state, the District of Columbia, or a possession or territory of the United States;

2. Has been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

3. Has had a health care provider license revoked or suspended by another state, the District of Columbia, or a territory of the United States, or has voluntarily surrendered any such license in lieu of having disciplinary action taken against the license; or

4. Has been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his or her name removed from the data bank. If the reported adverse action was a result of conduct that would not constitute a violation of any law or rule in this state, the board, or the department if there is no board, may:

a. Approve the application;

b. Approve the application with restrictions on the scope of practice of the licensee;

c. Approve the application with placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department if there is no board, may specify, including, but not limited to, requiring the applicant to submit to treatment, attend continuing education courses, or submit to reexamination; or

d. Deny the application.

Section 8. Section 486.112, Florida Statutes, is amended to


275506

read:

486.112 Physical Therapy Licensure Compact.—The Physical Therapy Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

ARTICLE I
PURPOSE AND OBJECTIVES

(1) The purpose of the compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The compact preserves the regulatory authority of member states to protect public health and safety through their current systems of state licensure. For purposes of state regulation under the compact, the practice of physical therapy is deemed to have occurred in the state where the patient is located at the time physical therapy is provided to the patient.

(2) The compact is designed to achieve all of the following objectives:

(a) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses.

(b) Enhance the states' ability to protect the public's health and safety.

(c) Encourage the cooperation of member states in regulating multistate physical therapy practice.

(d) Support spouses of relocating military members.

(e) Enhance the exchange of licensure, investigative, and



disciplinary information between member states.

(f) Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

ARTICLE II

DEFINITIONS

As used in the compact, and except as otherwise provided, the term:

(1) "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. chapter 1209 or chapter 1211.

(2) "Adverse action" means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

(3) "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a state's physical therapy licensing board. The term includes, but is not limited to, programs that address substance abuse issues.

(4) "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or physical therapist assistant in the remote state under its laws and rules.

(5) "Continuing competence" means a requirement, as a condition of license renewal, to provide evidence of participation in, and completion of, educational and professional activities relevant to the practice of physical



therapy.

(6) "Data system" means the coordinated database and reporting system created by the Physical Therapy Compact Commission for the exchange of information between member states relating to licensees or applicants under the compact, including identifying information, licensure data, investigative information, adverse actions, nonconfidential information related to alternative program participation, any denials of applications for licensure, and other information as specified by commission rule.

(7) "Encumbered license" means a license that a physical therapy licensing board has limited in any way.

(8) "Executive board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(9) "Home state" means the member state that is the licensee's primary state of residence.

(10) "Investigative information" means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

(11) "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a specific state.

(12) "Licensee" means an individual who currently holds an authorization from a state to practice as a physical therapist or physical therapist assistant.

(13) "Member state" means a state that has enacted the compact.

(14) "Party state" means any member state in which a


275506

licensee holds a current license or compact privilege or is applying for a license or compact privilege.

(15) "Physical therapist" means an individual licensed by a state to practice physical therapy.

(16)~~(15)~~ "Physical therapist assistant" means an individual licensed by a state to assist a physical therapist in specified areas of physical therapy.

(17)~~(16)~~ "Physical therapy" or "the practice of physical therapy" means the care and services provided by or under the direction and supervision of a licensed physical therapist.

(18)~~(17)~~ "Physical Therapy Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

(19)~~(18)~~ "Physical therapy licensing board" means the agency of a state which is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

(20)~~(19)~~ "Remote state" means a member state other than the home state where a licensee is exercising or seeking to exercise the compact privilege.

(21)~~(20)~~ "Rule" means a regulation, principle, or directive adopted by the commission which has the force of law.

(22)~~(21)~~ "State" means any state, commonwealth, district, or territory of the United States of America which regulates the practice of physical therapy.

ARTICLE III

STATE PARTICIPATION IN THE COMPACT



(1) To participate in the compact, a state must do all of the following:

(a) Participate fully in the commission's data system, including using the commission's unique identifier, as defined by commission rule.

(b) Have a mechanism in place for receiving and investigating complaints about licensees.

(c) Notify the commission, in accordance with the terms of the compact and rules, of any adverse action or the availability of investigative information regarding a licensee.

(d) Fully implement a criminal background check requirement, within a timeframe established by commission rule, which uses results from the Federal Bureau of Investigation record search on criminal background checks to make licensure decisions in accordance with subsection (2).

(e) Comply with the commission's rules.

(f) Use a recognized national examination as a requirement for licensure pursuant to the commission's rules.

(g) Have continuing competence requirements as a condition for license renewal.

(2) Upon adoption of the compact, a member state has the authority to obtain biometric-based information from each licensee applying for a compact privilege and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. s. 534 and 34 U.S.C. s. 40316.

(3) A member state must grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

275506

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise the compact privilege under the compact, a licensee must satisfy all of the following conditions:

(a) Hold a license in the home state.

(b) Not have an encumbrance on any state license.

(c) Be eligible for a compact privilege in all member states in accordance with subsections (4), (7), and (8).

(d) Not have had an adverse action against any license or compact privilege within the preceding 2 years.

(e) Notify the commission that the licensee is seeking the compact privilege within a remote state.

(f) Meet any jurisprudence requirements established by the remote state in which the licensee is seeking a compact privilege.

(g) Report to the commission adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) The compact privilege is valid until the expiration date of the home license. The licensee must continue to meet the requirements of subsection (1) to maintain the compact privilege in a remote state.

(3) A licensee providing physical therapy in a remote state under the compact privilege must comply with the laws and rules of the remote state.

(4) A licensee providing physical therapy in a remote state is subject to that state’s regulatory authority. A remote state



may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any member state until the specific period of time for removal has ended and all fines are paid.

(5) If a home state license is encumbered, the licensee loses the compact privilege in any remote state until the following conditions are met:

(a) The home state license is no longer encumbered.

(b) Two years have elapsed from the date of the adverse action.

(6) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in any remote state.

(7) If a licensee's compact privilege in any remote state is removed, the licensee loses the compact privilege in all remote states until all of the following conditions are met:

(a) The specific period of time for which the compact privilege was removed has ended.

(b) All fines have been paid.

(c) Two years have elapsed from the date of the adverse action.

(8) Once the requirements of subsection (7) have been met, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in a remote state.



ARTICLE V

ACTIVE DUTY MILITARY PERSONNEL

AND THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may choose any of the following locations to designate his or her home state:

(1) Home of record.

(2) Permanent change of station location.

(3) State of current residence, if it is different from the home of record or permanent change of station location.

ARTICLE VI

ADVERSE ACTIONS

(1) A home state has exclusive power to impose adverse action against a license issued by the home state.

(2) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

(3) The compact does not override a member state’s decision that participation in an alternative program may be used in lieu of adverse action and that such participation remain nonpublic if required by the member state’s laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

(4) A member state may investigate actual or alleged

275506

violations of the laws and rules for the practice of physical therapy committed in any other member state by a physical therapist or physical therapist assistant practicing under the compact who holds a license or compact privilege in such other member state.

(5) A remote state may do any of the following:

(a) Take adverse actions as set forth in subsection (4) of Article IV against a licensee's compact privilege in the state.

(b) Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party ~~member~~ state for the attendance and testimony of witnesses or for the production of evidence from another party ~~member~~ state must be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service laws of the state where the witnesses or evidence is located.

(c) If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

(6)(a) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint

275506

or individual investigation initiated under the compact.

ARTICLE VII
ESTABLISHMENT OF THE
PHYSICAL THERAPY COMPACT COMMISSION

(1) COMMISSION CREATED.—The member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

(a) The commission is an instrumentality of the member states.

(b) Venue is proper, and judicial proceedings by or against the commission must be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) The compact may not be construed to be a waiver of sovereign immunity.

(2) MEMBERSHIP, VOTING, AND MEETINGS.—

(a) Each member state has and is limited to one delegate selected by that member state's physical therapy licensing board to serve on the commission. The delegate must be a current member of the physical therapy licensing board who is a physical therapist, a physical therapist assistant, a public member, or the board administrator.

(b) A delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring on the commission must be



filled by the physical therapy licensing board of the member state for which the vacancy exists.

(c) Each delegate is entitled to one vote with regard to the adoption of rules and bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

(d) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(e) The commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws.

(f) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in Article IX.

(g) The commission or the executive board or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive board or other committees of the commission must discuss any of the following:

1. Noncompliance of a member state with its obligations under the compact.

2. The employment, compensation, or discipline of, or other matters, practices, or procedures related to, specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation against the commission, executive board, or other committees of the commission.



4. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.

5. An accusation of any person of a crime or a formal censure of any person.

6. Information disclosing trade secrets or commercial or financial information that is privileged or confidential.

7. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.

8. Investigatory records compiled for law enforcement purposes.

9. Information related to any investigative reports prepared by or on behalf of or for use of the commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact.

10. Matters specifically exempted from disclosure by federal or member state statute.

(h) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission’s legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(i) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action must be identified in the minutes. All minutes and documents of a closed meeting must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

275506

(3) DUTIES.—The commission shall do all of the following:

(a) Establish the fiscal year of the commission.

(b) Establish bylaws.

(c) Maintain its financial records in accordance with the bylaws.

(d) Meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(4) POWERS.—The commission may do any of the following:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules have the force and effect of law and are binding in all member states.

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law is not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(e) Hire employees and elect or appoint officers; fix the compensation of, define the duties of, and grant appropriate authority to such individuals to carry out the purposes of the compact; and establish the commission’s personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(f) Accept any appropriate donations and grants of money, equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that at all times the commission avoids any appearance of impropriety or conflict of



interest.

(g) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(h) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(i) Establish a budget and make expenditures.

(j) Borrow money.

(k) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in the compact and the bylaws.

(l) Provide information to, receive information from, and cooperate with law enforcement agencies.

(m) Establish and elect an executive board.

(n) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of physical therapy licensure and practice.

(5) THE EXECUTIVE BOARD.—

(a) The executive board may act on behalf of the commission according to the terms of the compact.

(b) The executive board shall be composed of the following nine members:

1. Seven voting members who are elected by the commission from the current membership of the commission.



2. One ex officio, nonvoting member from the recognized national physical therapy professional association.

3. One ex officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

(c) The ex officio members shall be selected by their respective organizations.

(d) The commission may remove any member of the executive board as provided in its bylaws.

(e) The executive board shall meet at least annually.

(f) The executive board shall do all of the following:

1. Recommend to the entire commission changes to the rules or bylaws, compact legislation, fees paid by compact member states, such as annual dues, and any commission compact fee charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractually or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Perform other duties as provided in the rules or bylaws.

(6) FINANCING OF THE COMMISSION.—

(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The commission may accept any appropriate revenue sources, donations, and grants of money, equipment, supplies,



materials, and services.

(c) The commission may levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must total to an amount sufficient to cover the commission's annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based upon a formula to be determined by the commission, which shall adopt a rule binding upon all member states.

(d) The commission may not incur obligations of any kind before securing the funds adequate to meet such obligations; nor may the commission pledge the credit of any of the member states, except by and with the authority of the member state.

(e) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION.—

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, whether personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual



or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, this paragraph may not be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection may not be construed to prohibit any member, officer, executive director, employee, or representative of the commission from retaining his or her own counsel or to require the commission to defend such person if the actual or alleged act, error, or omission resulted from that person's intentional, willful, or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities,



provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states.

(2) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission, which data set must include all of the following:

(a) Identifying information.

(b) Licensure data.

(c) Investigative information.

(d) Adverse actions against a license or compact privilege.

(e) Nonconfidential information related to alternative program participation.

(f) Any denial of application for licensure, and the reason for such denial.

(g) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Investigative information in the system pertaining to a licensee in any party ~~member~~ state must be available only to



other member states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license in a member state. Adverse action information pertaining to a licensee in any member state must be available to all other member states.

(5) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

(6) Any information submitted to the data system which is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE IX

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, such rule does not have further force and effect in any member state.

(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule by the commission, and



at least 30 days before the meeting at which the rule will be considered and voted upon, the commission must file a notice of proposed rulemaking on all of the following:

(a) The website of the commission or another publicly accessible platform.

(b) The website of each member state physical therapy licensing board or another publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed date, time, and location of the meeting in which the rule or amendment will be considered and voted upon.

(b) The text of the proposed rule or amendment and the reason for the proposed rule.

(c) A request for comments on the proposed rule or amendment from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before adoption of a proposed rule or amendment, the commission must allow persons to submit written data, facts, opinions, and arguments, which must be made available to the public.

(7) The commission must grant an opportunity for a public hearing before it adopts a rule or an amendment if a hearing is requested by any of the following:

(a) At least 25 persons.

(b) A state or federal governmental subdivision or agency.



(c) An association having at least 25 members.

(8) If a scheduled public hearing is held on the proposed rule or amendment, the commission must publish the date, time, and location of the hearing. If the hearing is held through electronic means, the commission must publish the mechanism for access to the electronic hearing.

(a) All persons wishing to be heard at the hearing must notify the executive director of the commission or another designated member in writing of their desire to appear and testify at the hearing at least 5 business days before the scheduled date of the hearing.

(b) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(c) All hearings must be recorded. A copy of the recording must be made available on request.

(d) This article may not be construed to require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(9) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(10) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public hearing.

(11) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the



effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this article are retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to do any of the following:

(a) Meet an imminent threat to public health, safety, or welfare.

(b) Prevent a loss of commission or member state funds.

(c) Meet a deadline for the adoption of an administrative rule established by federal law or rule.

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of the commission. The revision is subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the commission before the end of the notice period. If a challenge is not made, the revision takes effect without further action. If the revision is



challenged, the revision may not take effect without the approval of the commission.

ARTICLE X
OVERSIGHT, DISPUTE RESOLUTION,
AND ENFORCEMENT

(1) OVERSIGHT.—

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and take all actions necessary and appropriate to carry out the compact's purposes and intent. The provisions of the compact and the rules adopted pursuant thereto shall have standing as statutory law.

(b) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities, or actions of the commission.

(c) The commission is entitled to receive service of process in any such proceeding and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission renders a judgment or an order void as to the commission, the compact, or the adopted rules.

(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION.—

(a) If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or the adopted rules, the commission must do all of the following:



1. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, and any other action to be taken by the commission.

2. Provide remedial training and specific technical assistance regarding the default.

(b) If a state in default fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states, and all rights, privileges, and benefits conferred by the compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(c) Termination of membership in the compact may be imposed only after all other means of securing compliance have been exhausted. The commission shall give notice of intent to suspend or terminate a defaulting member state to the governor and majority and minority leaders of the defaulting state's legislature and to each of the member states.

(d) A state that has been terminated from the compact is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(e) The commission does not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting state.

(f) The defaulting state may appeal the action of the



commission by petitioning the United States District Court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(3) DISPUTE RESOLUTION.—

(a) Upon request by a member state, the commission must attempt to resolve disputes related to the compact which arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(4) ENFORCEMENT.—

(a) The commission, in the reasonable exercise of its discretion, shall enforce the compact and the commission's rules.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) The remedies under this article are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

275506

ARTICLE XI
DATE OF IMPLEMENTATION OF THE
PHYSICAL THERAPY COMPACT
AND ASSOCIATED RULES;
WITHDRAWAL; AND AMENDMENTS

(1) The compact becomes effective on the date that the compact statute is enacted into law in the tenth member state. The provisions that become effective at that time are limited to the powers granted to the commission relating to assembly and the adoption of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary for the implementation and administration of the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date that the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) Any member state may withdraw from the compact by enacting a statute repealing the same.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act before the effective date of withdrawal.

(4) The compact may not be construed to invalidate or


275506

prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state which does not conflict with the provisions of the compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding upon any member state until it is enacted into the laws of all member states.

ARTICLE XII
CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to carry out the purposes thereof. The provisions of the compact are severable, and if any phrase, clause, sentence, or provision of the compact is declared to be contrary to the constitution of any party ~~member~~ state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If the compact is held contrary to the constitution of any party ~~member~~ state, the compact remains in full force and effect as to the remaining party ~~member~~ states and in full force and effect as to the party ~~member~~ state affected as to all severable matters.

Section 9. Paragraph (d) of subsection (3) of section 766.1115, Florida Statutes, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—



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

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician or physician assistant licensed under chapter 458.

5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced practice registered nurse licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association and its employees or a corporate medical group and its employees.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.



14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.

15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9. and 13.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

Section 10. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, or, if this act fails to become a law until after June 1, 2025, it shall take effect upon becoming a law and shall operate retroactively to June 1, 2025, this act shall take effect July 1, 2025.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

275506

An act relating to the Department of Health; reenacting ss. 381.00316(2)(g) and 381.00319(1)(e), F.S., relating to the prohibition on discrimination by governmental and business entities based on health care choices and the prohibition on mask mandates and vaccination and testing mandates for educational institutions, respectively, for purposes of preserving the definition of the term "messenger ribonucleic acid vaccine" notwithstanding its scheduled repeal; repealing s. 9 of chapter 2023-43, Laws of Florida, which provides for the repeal of the definition of the term "messenger ribonucleic acid vaccine"; amending s. 381.026, F.S.; revising the rights of patients, which each health care provider and facility are required to observe, to include that such facilities and providers may not discriminate based on a patient's vaccination status; amending s. 381.986, F.S.; deleting the requirement that all officers and board members of medical marijuana treatment centers pass a background screening; defining terms for purposes of background screening requirements for persons affiliated with medical marijuana treatment centers; requiring medical marijuana treatment centers to notify the Department of Health through electronic mail within a specified timeframe after an actual or attempted theft, diversion, or loss of marijuana; requiring medical marijuana treatment centers to report attempted thefts, in addition to actual thefts, to law enforcement within a specified timeframe; amending s.


275506

381.988, F.S.; defining terms for purposes of background screening requirements for persons affiliated with medical marijuana testing laboratories; amending s. 456.0145, F.S.; revising eligibility criteria for licensure by endorsement under the MOBILE Act; amending s. 486.112, F.S.; defining the term "party state"; authorizing a remote state to issue subpoenas to individuals to testify or for the production of evidence from a party located in a party state; providing that such subpoenas are enforceable in the party state; requiring that investigative information in a certain system be available to a licensee in any party state; revising construction and severability of the compact to conform to changes made by the act; amending s. 766.1115, F.S.; revising the definition of the term "health care provider" or "provider"; providing effective dates.

978704

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Collins) recommended the following:

Senate Amendment to Amendment (275506) (with title amendment)

Between lines 792 and 793
insert:

Section 8. Subsection (1) of section 458.315, Florida Statutes, is amended to read:

458.315 Temporary certificate for practice in areas of critical need.—

(1) A physician ~~or physician assistant who is~~ licensed to

978704

practice in any jurisdiction of the United States ~~and~~ whose license is currently valid may be issued a temporary certificate for practice in areas of critical need. A physician seeking such certificate must pay an application fee of $300. A physician assistant licensed to practice in any state of the United States or the District of Columbia whose license is currently valid may be issued a temporary certificate for practice in areas of critical need.

Section 9. Subsection (1) of section 459.0076, Florida Statutes, is amended to read:

459.0076 Temporary certificate for practice in areas of critical need.—

(1) A physician ~~or physician assistant~~ who holds a valid license to practice in any jurisdiction of the United States may be issued a temporary certificate for practice in areas of critical need. A physician seeking such certificate must pay an application fee of $300. A physician assistant licensed to practice in any state of the United States or the District of Columbia whose license is currently valid may be issued a temporary certificate for practice in areas of critical need.

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

And the title is amended as follows:

Delete line 1669

and insert:

under the MOBILE Act; amending ss. 458.315 and 459.0076, F.S.; authorizing certain physician assistants to be issued temporary certificates for practice in areas of critical need; amending s.

978704

486.112, F.S.;

159816

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Collins) recommended the following:

Senate Amendment to Amendment (275506) (with title amendment)

Delete lines 1315 - 1316
and insert:
licensee in any member state must be available only to other party ~~member~~ states.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

159816

Delete lines 1675 - 1676

and insert:

investigative information pertaining to certain licensees in a certain system be available only to other party states; revising

By Senator Collins

14-00732C-25 20251270__

A bill to be entitled

An act relating to the Department of Health; reenacting ss. 381.00316(2)(g) and 381.00319(1)(e), F.S., relating to the prohibition on discrimination by governmental and businesses entities based on health care choices and the prohibition on mask mandates and vaccination and testing mandates for educational institutions, respectively, for purposes of preserving the definition of the term "messenger ribonucleic acid vaccine" notwithstanding its scheduled repeal; repealing s. 9 of chapter 2023-43, Laws of Florida, which provides for the repeal of the definition of the term "messenger ribonucleic acid vaccine"; amending s. 381.986, F.S.; deleting the requirement that all officers and board members of medical marijuana treatment centers pass a background screening; defining terms for purposes of background screening requirements for persons affiliated with medical marijuana treatment centers; requiring medical marijuana treatment centers to notify the Department of Health within a specified timeframe of an actual or attempted theft, diversion, or loss of marijuana; requiring medical marijuana treatment centers to report attempted thefts, in addition to actual thefts, to law enforcement within a specified timeframe; amending s. 381.988, F.S.; defining terms for purposes of background screening requirements for persons affiliated with medical marijuana testing laboratories; repealing ss. 383.141, 385.203, 391.221,

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

and 397.333, F.S., relating to the developmental disability information clearinghouse and advisory council, the Diabetes Advisory Council, the Statewide Children's Medical Services Network Advisory Council, and the Statewide Drug Policy Advisory Council, respectively; amending s. 409.818, F.S.; deleting the Florida Kidcare coordinating council; repealing ss. 413.271 and 514.028, F.S., relating to Florida Coordinating Council for the Deaf and Hard of Hearing and the advisory review board, respectively; amending s. 456.0145, F.S.; revising eligibility criteria for licensure by endorsement under the MOBILE Act; repealing s. 468.703, F.S., relating to the Board of Athletic Training; amending ss. 468.701, 468.705, 468.707, 468.709, 468.711, 468.713, 468.719, and 468.723, F.S.; conforming provisions to changes made by the act to make the department, instead of the Board of Athletic Training, responsible for regulating athletic training; repealing s. 468.801, F.S., relating to the Board of Orthotists and Prosthetists; amending ss. 468.80, 468.802, 468.803, 468.806, 468.808, 468.809, 468.8095, and 468.811, F.S.; conforming provisions to changes made by the act to make the department, instead of the Board of Orthotists and Prosthetists, responsible for regulating orthotics and prosthetics; repealing ss. 484.003 and 484.004, F.S., relating to the Board of Opticianry and board headquarters, respectively; amending ss. 484.002, 484.005, 484.006, 484.007,

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

484.008, 484.009, 484.011, 484.012, 484.013, 484.014, and 484.017, F.S.; conforming provisions to changes made by the act to make the department, instead of the Board of Opticianry, responsible for regulating opticianry; repealing ss. 484.042 and 484.043, F.S., relating to the Board of Hearing Aid Specialists and board headquarters, respectively; amending ss. 484.041, 484.044, 484.0445, 484.0447, 484.045, 484.047, 484.0501, 484.0512, 484.053, 484.056, and 484.059, F.S.; conforming provisions to changes made by the act to make the department, instead of the Board of Hearing Aid Specialists, responsible for regulating hearing aid specialists; amending s. 486.112, F.S.; defining the term "party state"; conforming provisions of the Physical Therapy Licensure Compact relating to adverse actions, the data system, and construction and severability to changes made by the act; amending ss. 20.43, 943.031, 943.042, and 1004.6495, F.S.; conforming provisions to changes made by the act; requiring the department to conduct a comprehensive study for a specified study of the boards and councils within the department; requiring the department to submit a report of its findings and recommendations to the Governor and the Legislature by a specified date; providing an effective date.

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

Section 1. Notwithstanding the scheduled repeal in section 9 of chapter 2023-43, Laws of Florida, paragraph (g) of subsection (2) of section 381.00316, Florida Statutes, is reenacted to read:

381.00316 Discrimination by governmental and business entities based on health care choices; prohibition.—

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

(g) "Messenger ribonucleic acid vaccine" means any vaccine that uses laboratory-produced messenger ribonucleic acid to trigger the human body's immune system to generate an immune response.

Section 2. Notwithstanding the scheduled repeal in section 9 of chapter 2023-43, Laws of Florida, paragraph (e) of subsection (1) of section 381.00319, Florida Statutes, is reenacted to read:

381.00319 Prohibition on mask mandates and vaccination and testing mandates for educational institutions.—

(1) For purposes of this section, the term:

(e) "Messenger ribonucleic acid vaccine" has the same meaning as in s. 381.00316.

Section 3. Section 9 of chapter 2023-43, Laws of Florida, is repealed.

Section 4. Paragraphs (b), (e), and (f) of subsection (8) of section 381.986, Florida Statutes, are amended to read:

381.986 Medical use of marijuana.—

(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(b) An applicant for licensure as a medical marijuana treatment center must ~~shall~~ apply to the department on a form prescribed by the department and adopted in rule. The department

shall adopt rules pursuant to ss. 120.536(1) and 120.54 establishing a procedure for the issuance and biennial renewal of licenses, including initial application and biennial renewal fees sufficient to cover the costs of implementing and administering this section, and establishing supplemental licensure fees for payment beginning May 1, 2018, sufficient to cover the costs of administering ss. 381.989 and 1004.4351. The department shall identify applicants with strong diversity plans reflecting this state's commitment to diversity and implement training programs and other educational programs to enable minority persons and minority business enterprises, as defined in s. 288.703, and veteran business enterprises, as defined in s. 295.187, to compete for medical marijuana treatment center licensure and contracts. Subject to the requirements in subparagraphs (a)2.-4., the department shall issue a license to an applicant if the applicant meets the requirements of this section and pays the initial application fee. The department shall renew the licensure of a medical marijuana treatment center biennially if the licensee meets the requirements of this section and pays the biennial renewal fee. However, the department may not renew the license of a medical marijuana treatment center that has not begun to cultivate, process, and dispense marijuana by the date that the medical marijuana treatment center is required to renew its license. An individual may not be an applicant, owner, officer, board member, or manager on more than one application for licensure as a medical marijuana treatment center. An individual or entity may not be awarded more than one license as a medical marijuana treatment center. An applicant for licensure as a medical marijuana

treatment center must demonstrate:

1. That, for the 5 consecutive years before submitting the application, the applicant has been registered to do business in this ~~the~~ state.

2. Possession of a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131.

3. The technical and technological ability to cultivate and produce marijuana, including, but not limited to, low-THC cannabis.

4. The ability to secure the premises, resources, and personnel necessary to operate as a medical marijuana treatment center.

5. The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.

6. An infrastructure reasonably located to dispense marijuana to registered qualified patients statewide or regionally as determined by the department.

7. The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financial statements to the department.

a. Upon approval, the applicant must post a $5 million performance bond issued by an authorized surety insurance company rated in one of the three highest rating categories by a nationally recognized rating service. However, a medical marijuana treatment center serving at least 1,000 qualified patients is only required to maintain a $2 million performance

bond.

b. In lieu of the performance bond required under sub-subparagraph a., the applicant may provide an irrevocable letter of credit payable to the department or provide cash to the department. If provided with cash under this sub-subparagraph, the department must ~~shall~~ deposit the cash in the Grants and Donations Trust Fund within the Department of Health, subject to the same conditions as the bond regarding requirements for the applicant to forfeit ownership of the funds. If the funds deposited under this sub-subparagraph generate interest, the amount of that interest must ~~shall~~ be used by the department for the administration of this section.

8. That all owners~~, officers, board members,~~ and managers have passed a background screening pursuant to subsection (9). As used in this subparagraph, the term:

a. "Manager" means any person with the authority to exercise or contribute to the operational control, direction, or management of an applicant or a medical marijuana treatment center or who has authority to supervise any employee of an applicant or a medical marijuana treatment center. This includes officers and board members.

b. "Owner" means any person who owns or controls a 5 percent or greater share of interests of the applicant or a medical marijuana treatment center which include beneficial or voting rights to interests. In the event that one person owns a beneficial right to interests and another person holds the voting rights with respect to such interests, then in such case, both are considered the owner of such interests.

9. The employment of a medical director to supervise the

activities of the medical marijuana treatment center.

10. A diversity plan that promotes and ensures the involvement of minority persons and minority business enterprises, as defined in s. 288.703, or veteran business enterprises, as defined in s. 295.187, in ownership, management, and employment. An applicant for licensure renewal must show the effectiveness of the diversity plan by including the following with his or her application for renewal:

a. Representation of minority persons and veterans in the medical marijuana treatment center's workforce;

b. Efforts to recruit minority persons and veterans for employment; and

c. A record of contracts for services with minority business enterprises and veteran business enterprises.

(e) A licensed medical marijuana treatment center shall cultivate, process, transport, and dispense marijuana for medical use. A licensed medical marijuana treatment center may not contract for services directly related to the cultivation, processing, and dispensing of marijuana or marijuana delivery devices, except that a medical marijuana treatment center licensed pursuant to subparagraph (a)1. may contract with a single entity for the cultivation, processing, transporting, and dispensing of marijuana and marijuana delivery devices. A licensed medical marijuana treatment center shall ~~must~~, at all times, maintain compliance with the criteria demonstrated and representations made in the initial application and the criteria established in this subsection. Upon request, the department may grant a medical marijuana treatment center a variance from the representations made in the initial application. Consideration

of such a request must ~~shall~~ be based upon the individual facts and circumstances surrounding the request. A variance may not be granted unless the requesting medical marijuana treatment center can demonstrate to the department that it has a proposed alternative to the specific representation made in its application which fulfills the same or a similar purpose as the specific representation in a way that the department can reasonably determine will not be a lower standard than the specific representation in the application. A variance may not be granted from the requirements in subparagraph 2. and subparagraphs (b)1. and 2.

1. A licensed medical marijuana treatment center may transfer ownership to an individual or entity who meets the requirements of this section. A publicly traded corporation or publicly traded company that meets the requirements of this section is not precluded from ownership of a medical marijuana treatment center. To accommodate a change in ownership:

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

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

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

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

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

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

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

4. All employees of a medical marijuana treatment center must be 21 years of age or older and have passed a background screening pursuant to subsection (9). As used in this subparagraph, the term "employee" means any person who is employed by a medical marijuana treatment center licensee in any capacity, including those whose duties involve any aspect of the cultivation, processing, transportation, or dispensing of marijuana. This requirement applies to all employees, regardless of the compensation received.

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

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

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

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

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

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

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

8. A medical marijuana treatment center that produces edibles must hold a permit to operate as a food establishment pursuant to chapter 500, the Florida Food Safety Act, and must comply with all the requirements for food establishments pursuant to chapter 500 and any rules adopted thereunder. Edibles may not contain more than 200 milligrams of

tetrahydrocannabinol, and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may not have a potency variance ~~of no~~ greater than 15 percent. Marijuana products, including edibles, may not be attractive to children; be manufactured in the shape of humans, cartoons, or animals; be manufactured in a form that bears any reasonable resemblance to products available for consumption as commercially available candy; or contain any color additives. To discourage consumption of edibles by children, the department shall determine by rule any shapes, forms, and ingredients allowed and prohibited for edibles. Medical marijuana treatment centers may not begin processing or dispensing edibles until after the effective date of the rule. The department shall also adopt sanitation rules providing the standards and requirements for the storage, display, or dispensing of edibles.

9. Within 12 months after licensure, a medical marijuana treatment center must demonstrate to the department that all of its processing facilities have passed a Food Safety Good Manufacturing Practices, such as Global Food Safety Initiative or equivalent, inspection by a nationally accredited certifying body. A medical marijuana treatment center must immediately stop processing at any facility which fails to pass this inspection until it demonstrates to the department that such facility has met this requirement.

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

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

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

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

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

d. Test the processed marijuana using a medical marijuana testing laboratory before it is dispensed. Results must be verified and signed by two medical marijuana treatment center employees. Before dispensing, the medical marijuana treatment center must determine that the test results indicate that low-THC cannabis meets the definition of low-THC cannabis, the concentration of tetrahydrocannabinol meets the potency requirements of this section, the labeling of the concentration of tetrahydrocannabinol and cannabidiol is accurate, and all marijuana is safe for human consumption and free from contaminants that are unsafe for human consumption. The department shall determine by rule which contaminants must be tested for and the maximum levels of each contaminant which are safe for human consumption. The Department of Agriculture and

Consumer Services shall assist the department in developing the testing requirements for contaminants that are unsafe for human consumption in edibles. The department shall also determine by rule the procedures for the treatment of marijuana that fails to meet the testing requirements of this section, s. 381.988, or department rule. The department may select samples of marijuana from a medical marijuana treatment center facility which shall be tested by the department to determine whether the marijuana meets the potency requirements of this section, is safe for human consumption, and is accurately labeled with the tetrahydrocannabinol and cannabidiol concentration or to verify the result of marijuana testing conducted by a marijuana testing laboratory. The department may also select samples of marijuana delivery devices from a medical marijuana treatment center to determine whether the marijuana delivery device is safe for use by qualified patients. A medical marijuana treatment center may not require payment from the department for the sample. A medical marijuana treatment center must recall marijuana, including all marijuana and marijuana products made from the same batch of marijuana, that fails to meet the potency requirements of this section, that is unsafe for human consumption, or for which the labeling of the tetrahydrocannabinol and cannabidiol concentration is inaccurate. The department shall adopt rules to establish marijuana potency variations of no greater than 15 percent using negotiated rulemaking pursuant to s. 120.54(2)(d) which accounts for, but is not limited to, time lapses between testing, testing methods, testing instruments, and types of marijuana sampled for testing. The department may not issue any recalls for product

potency as it relates to product labeling before issuing a rule relating to potency variation standards. A medical marijuana treatment center must also recall all marijuana delivery devices determined to be unsafe for use by qualified patients. The medical marijuana treatment center must retain records of all testing and samples of each homogeneous batch of marijuana for at least 9 months. The medical marijuana treatment center must contract with a marijuana testing laboratory to perform audits on the medical marijuana treatment center's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the marijuana or low-THC cannabis meets the requirements of this section and that the marijuana or low-THC cannabis is safe for human consumption. A medical marijuana treatment center shall reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of such audits. A medical marijuana treatment center may use a laboratory that has not been certified by the department under s. 381.988 until such time as at least one laboratory holds the required certification, but in no event later than July 1, 2018.

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

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

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

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

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

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

(V) The name of the patient.

(VI) The product name, if applicable, and dosage form, including concentration of tetrahydrocannabinol and cannabidiol. The product name may not contain wording commonly associated with products that are attractive to children or which promote the recreational use of marijuana.

(VII) The recommended dose.

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

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

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

a. Clinical pharmacology.

b. Indications and use.

c. Dosage and administration.

d. Dosage forms and strengths.

e. Contraindications.

f. Warnings and precautions.

g. Adverse reactions.

13. In addition to the packaging and labeling requirements specified in subparagraphs 11. and 12., marijuana in a form for smoking must be packaged in a sealed receptacle with a legible and prominent warning to keep away from children and a warning

that states marijuana smoke contains carcinogens and may negatively affect health. Such receptacles for marijuana in a form for smoking must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol.

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

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

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

a. May dispense any active, valid order for low-THC cannabis, medical cannabis and cannabis delivery devices issued pursuant to former s. 381.986, Florida Statutes 2016, which was

entered into the medical marijuana use registry before July 1, 2017.

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

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

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

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

f. May not dispense or sell any other type of cannabis, alcohol, or illicit drug-related product, including pipes or wrapping papers made with tobacco or hemp, other than a marijuana delivery device required for the medical use of

marijuana and which is specified in a physician certification.

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

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

(f) To ensure the safety and security of premises where the cultivation, processing, storing, or dispensing of marijuana occurs, and to maintain adequate controls against the diversion, theft, and loss of marijuana or marijuana delivery devices, a medical marijuana treatment center shall:

1.a. Maintain a fully operational security alarm system that secures all entry points and perimeter windows and is equipped with motion detectors; pressure switches; and duress, panic, and hold-up alarms; and

b. Maintain a video surveillance system that records continuously 24 hours a day and meets the following criteria:

(I) Cameras are fixed in a place that allows for the clear identification of persons and activities in controlled areas of the premises. Controlled areas include grow rooms, processing rooms, storage rooms, disposal rooms or areas, and point-of-sale rooms.

(II) Cameras are fixed in entrances and exits to the premises, which must ~~shall~~ record from both indoor and outdoor, or ingress and egress, vantage points.

(III) Recorded images must clearly and accurately display the time and date.

(IV) Retain video surveillance recordings for at least 45 days or longer upon the request of a law enforcement agency.

2. Ensure that the medical marijuana treatment center's outdoor premises have sufficient lighting from dusk until dawn.

3. Ensure that the indoor premises where dispensing occurs includes a waiting area with sufficient space and seating to accommodate qualified patients and caregivers and at least one private consultation area that is isolated from the waiting area and area where dispensing occurs. A medical marijuana treatment center may not display products or dispense marijuana or marijuana delivery devices in the waiting area.

4. Not dispense from its premises marijuana or a marijuana delivery device between the hours of 9 p.m. and 7 a.m., but may perform all other operations and deliver marijuana to qualified patients 24 hours a day.

5. Store marijuana in a secured, locked room or a vault.

6. Require at least two of its employees, or two employees of a security agency with whom it contracts, to be on the premises at all times where cultivation, processing, or storing of marijuana occurs.

7. Require each employee or contractor to wear a photo identification badge at all times while on the premises.

8. Require each visitor to wear a visitor pass at all times while on the premises.

9. Implement an alcohol and drug-free workplace policy.

10. Report to local law enforcement and notify the department through electronic mail within 24 hours after the

medical marijuana treatment center is notified or becomes aware of any actual or attempted ~~the~~ theft, diversion, or loss of marijuana.

Section 5. Paragraph (d) of subsection (1) of section 381.988, Florida Statutes, is amended to read:

381.988 Medical marijuana testing laboratories; marijuana tests conducted by a certified laboratory.—

(1) A person or entity seeking to be a certified marijuana testing laboratory must:

(d) Require all employees, owners, and managers to submit to and pass a level 2 background screening pursuant to chapter 435. The department shall deny certification if the person or entity seeking certification has a disqualifying offense as provided in s. 435.04 or has an arrest awaiting final disposition for, has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in chapter 837, chapter 895, or chapter 896 or similar law of another jurisdiction. Exemptions from disqualification as provided under s. 435.07 do not apply to this paragraph.

1. As used in this paragraph, the term:

a. "Employee" means any person whose duties or activities involve any aspect of regulatory compliance testing or research and development testing of marijuana for a certified marijuana testing laboratory, regardless of whether such person is compensated for his or her work.

b. "Manager" means any person with authority to exercise or contribute to the operational control, direction, or management of an applicant or certified marijuana testing laboratory or who

has authority to supervise any employee of an applicant or a certified marijuana testing laboratory. This includes officers and board members.

c. "Owner" means any person who owns or controls a 5 percent or greater share of interests of the applicant or a certified marijuana testing laboratory which include beneficial or voting rights to interests. In the event that one person owns a beneficial right to interests and another person holds the voting rights with respect to such interests, then in such case, both are considered the owner of such interests.

2. Such employees, owners, and managers must submit a full set of fingerprints to the department or to a vendor, entity, or agency authorized by s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing.

3.~~2.~~ Fees for state and federal fingerprint processing and retention must ~~shall~~ be borne by the certified marijuana testing laboratory. The state cost for fingerprint processing is ~~shall be~~ as provided in s. 943.053(3)(e) for records provided to persons or entities other than those specified as exceptions therein.

4.~~3.~~ Fingerprints submitted to the Department of Law Enforcement pursuant to this paragraph must ~~shall~~ be retained by the Department of Law Enforcement as provided in s. 943.05(2)(g) and (h) and, when the Department of Law Enforcement begins participation in the program, enrolled in the Federal Bureau of Investigation's national retained print arrest notification

program. Any arrest record identified must ~~shall~~ be reported to the department.

Section 6. Section 383.141, Florida Statutes, is repealed.

Section 7. Section 385.203, Florida Statutes, is repealed.

Section 8. Section 391.221, Florida Statutes, is repealed.

Section 9. Section 397.333, Florida Statutes, is repealed.

Section 10. Paragraph (b) of subsection (2) of section 409.818, Florida Statutes, is amended to read:

409.818 Administration.—In order to implement ss. 409.810-409.821, the following agencies shall have the following duties:

(2) The Department of Health shall:

~~(b) Chair a state-level Florida Kidcare coordinating council to review and make recommendations concerning the implementation and operation of the program. The coordinating council shall include representatives from the department, the Department of Children and Families, the agency, the Florida Healthy Kids Corporation, the Office of Insurance Regulation of the Financial Services Commission, local government, health insurers, health maintenance organizations, health care providers, families participating in the program, and organizations representing low-income families.~~

Section 11. Section 413.271, Florida Statutes, is repealed.

Section 12. Section 514.028, Florida Statutes, is repealed.

Section 13. Paragraphs (a) and (c) of subsection (2) of section 456.0145, Florida Statutes, are amended to read:

456.0145 Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.—

(2) LICENSURE BY ENDORSEMENT.—

(a) An applicable board, or the department if there is no

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board, shall issue a license to practice in this state to an applicant who meets all of the following criteria:

1. Submits a complete application.

2. Holds an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice, as determined by the board or department, as applicable. The term "scope of practice" means the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license issued in this state.

3.a. Has obtained a passing score on a national licensure examination or holds a national certification recognized by the board, or the department if there is no board, as applicable to the profession for which the applicant is seeking licensure in this state; or

b. Meets the requirements of paragraph (b).

4. Has actively practiced the profession for which the applicant is applying for at least 2 ~~3~~ years during the 4-year period immediately preceding the date of submission of the application.

5. Attests that he or she is not, at the time of submission of the application, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reasons related to the practice of the profession for which he or she is applying.

6. Has not had disciplinary action taken against him or her in the 5 years immediately preceding the date of submission of the application.

7. Meets the financial responsibility requirements of s. 456.048 or the applicable practice act, if required for the profession for which the applicant is seeking licensure.

8. Submits a set of fingerprints for a background screening pursuant to s. 456.0135, if required for the profession for which he or she is applying.

The department shall verify information submitted by the applicant under this subsection using the National Practitioner Data Bank, as applicable.

(c) A person is ineligible for a license under this section if he or she:

1. Has a complaint, an allegation, or an investigation pending before a licensing entity in another state, the District of Columbia, or a possession or territory of the United States;

2. Has been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

3. Has had a health care provider license revoked or suspended by another state, the District of Columbia, or a territory of the United States, or has voluntarily surrendered any such license in lieu of having disciplinary action taken against the license; or

4. Has been reported to the National Practitioner Data Bank, unless the reported adverse action was a result of conduct that would not constitute a violation of any law or rule in this state ~~applicant has successfully appealed to have his or her name removed from the data bank~~.

Section 14. Subsection (3) of section 468.701, Florida

Statutes, is amended to read:

468.701 Definitions.—As used in this part, the term:

~~(3) "Board" means the Board of Athletic Training.~~

Section 15. Section 468.703, Florida Statutes, is repealed.

Section 16. Section 468.705, Florida Statutes, is amended to read:

468.705 Rulemaking authority.—The department may ~~board is authorized to~~ adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part conferring duties upon it. ~~The provisions of s. 456.011(5) shall apply to the board's activity.~~ Such rules must ~~shall~~ include, but are not ~~be~~ limited to, the allowable scope of practice regarding the use of equipment, procedures, and medication; mandatory requirements and guidelines for communication between the athletic trainer and a physician, including the reporting to the physician of new or recurring injuries or conditions; licensure requirements; licensure examination; continuing education requirements; fees; records and reports to be filed by licensees; protocols; and any other requirements necessary to regulate the practice of athletic training.

Section 17. Section 468.707, Florida Statutes, is amended to read:

468.707 Licensure requirements.—Any person desiring to be licensed as an athletic trainer must ~~shall~~ apply to the department on a form approved by the department. An applicant must ~~shall~~ also provide records or other evidence, as determined by the department ~~board~~, to prove he or she has met the requirements of this section. The department shall license each applicant who:

(1) Has completed the application form and remitted the required fees.

(2) Has submitted to background screening pursuant to s. 456.0135. ~~The board may require a background screening for an applicant whose license has expired or who is undergoing disciplinary action.~~

(3)(a) Has obtained, at a minimum, a bachelor's degree from a college or university professional athletic training degree program accredited by the Commission on Accreditation of Athletic Training Education or its successor organization recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, approved by the department ~~board~~, or recognized by the Board of Certification, and has passed the national examination to be certified by the Board of Certification; or

(b) Has obtained, at a minimum, a bachelor's degree, has completed the Board of Certification internship requirements, and holds a current certification from the Board of Certification.

(4) Has current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator set forth in the continuing education requirements as determined by the department ~~board~~ pursuant to s. 468.711.

(5) Has completed any other requirements as determined by the department ~~and approved by the board~~.

Section 18. Section 468.709, Florida Statutes, is amended to read:

468.709 Fees.—

(1) The department ~~board~~ shall, by rule, establish fees for

the following purposes:

(a) An application fee, not to exceed $100.

(b) An initial licensure fee, not to exceed $200.

(c) A biennial renewal fee, not to exceed $200.

(d) An inactive fee, not to exceed $100.

(e) A delinquent fee, not to exceed $100.

(f) A reactivation fee, not to exceed $100.

(g) A voluntary inactive fee, not to exceed $100.

(2) The department ~~board~~ shall establish fees at a level, not to exceed the statutory fee cap, that is adequate to ensure the continued operation of the regulatory program under this part. The department may not ~~board shall neither~~ set or ~~nor~~ maintain the fees at a level that will substantially exceed this need.

Section 19. Subsection (2) of section 468.711, Florida Statutes, is amended to read:

468.711 Renewal of license; continuing education.—

(2) The department ~~board~~ may, by rule, prescribe continuing education requirements, not to exceed 24 hours biennially. The criteria for continuing education must ~~shall~~ be approved by the department ~~board~~ and must include a current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator as set forth in the continuing education requirements as determined by the department ~~board~~.

Section 20. Subsection (2) of section 468.713, Florida Statutes, is amended to read:

468.713 Responsibilities of athletic trainers.—

(2) An athletic trainer shall work within his or her allowable scope of practice as specified by department ~~board~~

rule under s. 468.705. An athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide or that he or she is otherwise prohibited by law from providing.

Section 21. Subsection (2) of section 468.719, Florida Statutes, is amended to read:

468.719 Disciplinary actions.—

(2) The department ~~board~~ may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

Section 22. Subsection (2) of section 468.723, Florida Statutes, is amended to read:

468.723 Exemptions.—This part does not prohibit or restrict:

(2) An athletic training student acting under the direct supervision of a licensed athletic trainer. For purposes of this subsection, the term "direct supervision" means the physical presence of an athletic trainer so that the athletic trainer is immediately available to the athletic training student and able to intervene on behalf of the athletic training student. The supervision must comply with department ~~board~~ rule.

Section 23. Subsections (2), (4), (5), and (18) of section 468.80, Florida Statutes, are amended to read:

468.80 Definitions.—As used in this part, the term:

~~(2) "Board" means the Board of Orthotists and Prosthetists.~~

(3)~~(4)~~ "Internship" means a program in which a person receives clinical experience under the supervision of a licensed orthotist or prosthetist as defined by department ~~the board~~ by rule.

(4)~~(5)~~ "Mandatory courses" means continuing education courses that the department ~~board~~ has defined by rule and required for license issuance or renewal. Notwithstanding s. 456.013(7), the department ~~board~~ shall require completion of a 1-hour course relating to the prevention of medical errors as a part of the licensure issuance and biennial renewal process. The 1-hour medical errors course counts toward the total number of continuing education hours required. The course must be approved by the department ~~board~~, be developed specifically for the field of orthotics and prosthetics, and include a study of root-cause analysis, error reduction and prevention, patient safety, and medical records.

(17)~~(18)~~ "Resident" means a person registered to practice orthotics or prosthetics under the supervision of a licensed orthotist or prosthetist as defined by ~~the~~ department ~~board by~~ rule.

Section 24. Section 468.801, Florida Statutes, is repealed.

Section 25. Section 468.802, Florida Statutes, is amended to read:

468.802 Authority to adopt rules.—The department ~~board~~ shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement ~~the provisions of~~ this part, including rules relating to standards of practice for orthotists, orthotic fitters, orthotic fitter assistants, pedorthists, prosthetists, and residents.

Section 26. Subsections (2) through (5) of section 468.803, Florida Statutes, as amended by section 25, chapter 2024-243, Laws of Florida, are amended to read:

468.803 License, registration, and examination requirements.—

(2) An applicant for registration, examination, or licensure must apply to the department on a form prescribed by the department ~~board for consideration of board approval~~. Each initial applicant must ~~shall~~ submit fingerprints to the department in accordance with s. 456.0135 and any other procedures specified by the department for state and national criminal history checks of the applicant. The department ~~board~~ shall screen the results to determine if an applicant meets licensure requirements. The department ~~board~~ shall consider for examination, registration, or licensure each applicant whom the department ~~board~~ verifies meets all of the following criteria:

(a) Has submitted the completed application and completed the fingerprinting requirements and has paid the applicable application fee, not to exceed $500. The application fee is nonrefundable.

(b) Is of good moral character.

(c) Is 18 years of age or older.

(d) Has completed the appropriate educational preparation.

(3) A person seeking to attain the orthotics or prosthetics experience required for licensure in this state must be approved by the department ~~board~~ and registered as a resident by the department. Although a registration may be held in both disciplines, for independent registrations the department ~~board~~ may not approve a second registration until at least 1 year

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

(a) A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs.

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

(c) A minimum of a bachelor's degree from an institutionally accredited college or university and a dual certificate in both orthotics and prosthetics from programs

recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the department ~~board~~.

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

(a) For an examination in orthotics:

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

2. An approved orthotics internship of 1 year of qualified experience, as determined by the department ~~board~~, or an

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orthotic residency or dual residency program recognized by the department ~~board~~.

(b) For an examination in prosthetics:

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

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

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

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

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

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

3. Completed the mandatory courses; and

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

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

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

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

3. Completed the mandatory courses; and

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

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

1. A high school diploma or its equivalent;

2. A minimum of 40 hours of training in orthotics education, as approved by the department ~~board~~;

3. Two years of supervised experience in orthotics acquired

after completion of the required education, as approved by the department ~~board~~; and

4. Completed the mandatory courses.

(d) An orthotic fitter assistant, the applicant must pay a license fee not to exceed $500 and must have:

1. A high school diploma or its equivalent;

2. A minimum of 40 hours of training in orthotics education, as approved by the department ~~board~~; and

3. Completed the mandatory courses.

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

1. A high school diploma or its equivalent;

2. A minimum of 120 hours of training, as approved by the department ~~board~~;

3. An internship of 80 hours of qualified working experience, as determined by the department ~~board~~; and

4. Completed the mandatory courses.

Section 27. Section 468.806, Florida Statutes, is amended to read:

468.806 Biennial renewal of license.—

(1) The department shall renew a license upon receipt of the required documentation, renewal application, and renewal fee, not to exceed $500, as set by the department ~~board~~. The applicant for license renewal must submit information necessary to conduct a statewide criminal history check along with payment in an amount equal to the costs incurred by the department for a statewide criminal history check. The department shall submit the required information for a statewide criminal history check of the applicant to the Department of Law Enforcement.

(2) The department ~~board~~ shall adopt rules establishing a procedure for the biennial license renewal.

(3) The department ~~board~~ may by rule prescribe continuing education requirements and approve course criteria, not to exceed 30 hours biennially, as a condition for license renewal. The department ~~board~~ shall establish by rule mandatory courses to safeguard the welfare of the public and licensed practitioners, standards and qualifications for continuing education courses, standards and qualifications for course providers, and a procedure for approving continuing education courses and providers and set a fee for continuing education course and provider approval.

Section 28. Section 468.808, Florida Statutes, is amended to read:

468.808 Support personnel.—A person must be licensed to practice orthotics, prosthetics, or pedorthics in this state. However, a licensed orthotist, prosthetist, or pedorthist may delegate duties, not to include patient evaluation, treatment formulation, or the final fitting of a device before ~~prior to~~ patient use, to nonlicensed support personnel. All other delegated duties must be performed under the supervision, as defined by department ~~the board by~~ rule, of a licensed orthotist, prosthetist, or pedorthist, and the persons acting as support personnel must be identified as such by wearing an identification tag as defined by department ~~the board by~~ rule. In such instances the supervising licensee is responsible for all acts performed by such persons.

Section 29. Paragraph (a) of subsection (1) of section 468.809, Florida Statutes, is amended to read:

468.809 Prohibitions; penalties.—

(1) A person may not:

(a) Make a false or fraudulent statement in any application, affidavit, or statement presented to the department ~~board~~ or in any proceeding before the department ~~board~~.

Section 30. Subsections (1) and (3) of section 468.8095, Florida Statutes, are amended to read:

468.8095 Practitioner and resident identification.—

(1) A licensee or person registered with the department shall post a license or registration and a recent photograph of the licensee or registrant at each facility where patients are seen by the licensee or registrant in a manner determined by department ~~the board by~~ rule. This requirement does not extend to areas where the licensee or registrant may visit and normally does not treat patients. The posted license or registration must be valid.

(3) During patient contact, each licensee or person registered with the department shall prominently wear an identification tag or badge with the name, recent photograph, and license or registration number, as applicable, of the licensee or registrant. The size and appearance of the identification tag or badge is ~~shall be~~ determined by department ~~the board by~~ rule. Persons licensed in more than one practice field under this part may list both license numbers. Licensees or registrants working in facilities requiring the wearing of a specific identification tag may substitute the identification tag or badge required by this subsection with the facility's design as determined by the department ~~board~~.

Section 31. Subsection (2) of section 468.811, Florida

Statutes, is amended to read:

468.811 Disciplinary proceedings.—

(2) The department ~~board~~ may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

Section 32. Subsections (2), (3), and (6) of section 484.002, Florida Statutes, are amended to read:

484.002 Definitions.—As used in this part:

(2) ~~"Board" means the Board of Opticianry.~~

~~(3)~~ "Opticianry" means the preparation and dispensing of lenses, spectacles, eyeglasses, contact lenses, and other optical devices to the intended user or agent thereof, upon the written prescription of a licensed allopathic or osteopathic physician or optometrist who is duly licensed to practice or upon presentation of a duplicate prescription. The selection of frame designs, the actual sales transaction, and the transfer of physical possession of lenses, spectacles, eyeglasses, contact lenses, and other optical devices subsequent to performance of all services of the optician are ~~shall~~ not ~~be~~ considered the practice of opticianry; however, such physical possession may ~~shall~~ not be transferred until the optician has completed the fitting of the optical device upon the customer. The practice of opticianry also includes the duplication of lenses accurately as to power, without prescription. A department-certified ~~board-certified~~ optician qualified and operating under rules established by the department ~~board~~ may fill, fit, adapt, or

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

dispense any soft contact lens prescription. Such optician may fill, fit, adapt, or dispense any extended wear or hard contact lens prescription to the extent authorized to do so by the prescribing allopathic or osteopathic physician or optometrist.

(5)~~(6)~~ "Department-certified ~~Board-certified~~ optician" means an optician licensed in this state who:

(a) Has passed the National Contact Lens Registry Examination;

(b) Has successfully completed a department-approved ~~board-approved~~ course of at least 20 contact hours covering the competencies required in fitting, adapting, and dispensing of contact lenses;

(c) Has met any other requirements established by the department ~~board~~ to assure competence in the fitting, adapting, and dispensing of contact lenses;

(d) Has completed the application form and remitted a nonrefundable application fee set by the department ~~board~~ not to exceed $100; and

(e) Has been issued a certificate by the department.

Section 33. Section 484.003, Florida Statutes, is repealed.

Section 34. Section 484.004, Florida Statutes, is repealed.

Section 35. Section 484.005, Florida Statutes, is amended to read:

484.005 Authority to make rules.—The department may ~~board has authority to~~ adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part conferring duties upon it. Such rules must ~~shall~~ include, but need not be limited to, rules relating to:

(1) A standard of practice for opticians licensed pursuant

to this part.

(2) Minimum equipment which must ~~shall~~ be used ~~utilized~~ to prepare, fit, measure, and dispense lenses, spectacles, eyeglasses, contact lenses, and other optical devices allowed under the practice of opticianry.

(3) Procedures for transfer of prescription files upon the going out of business of an optician, corporation, or other person.

(4) A standard of practice for filling prescriptions for contact lenses and fitting, adapting, and dispensing contact lenses.

Section 36. Section 484.006, Florida Statutes, is amended to read:

484.006 Certain rules prohibited.—The department may not adopt any rule or policy that prohibits:

(1) ~~No rule or policy of the board shall prohibit~~ Any optician from offering a discount in any form or manner in conjunction with the practice of opticianry or from advertising, either directly or indirectly by any means whatsoever, any definite or indefinite price or credit terms on prescriptive or corrective lenses, frames, complete prescriptive or corrective glasses, or other opticianry service.

(2) ~~No rule or policy of the board shall prohibit~~ Any optician from practicing jointly with optometrists or allopathic or osteopathic physicians licensed in this state.

(3) ~~No rule or policy of the board shall prohibit~~ The sale of spectacles for reading purposes; toy glasses; goggles or sunglasses consisting of plano white, plano colored, or plano tinted glasses; or readymade nonprescription glasses; nor may

~~shall~~ anything in this part be construed to affect in any way the manufacturing and sale of plastic or glass artificial eyes or any person engaged in the manufacturing or sale of plastic or glass artificial eyes.

(4) ~~No rule or policy of the board shall prohibit~~ Any optician licensed under this part from engaging in the practice of opticianry with, or in the employ of, any partnership, corporation, lay body, organization, group, or individual.

(5) ~~No rule or policy of the board shall prohibit~~ The location of offices or branch offices by an optician.

(6) ~~No rule or policy of the board shall prohibit~~ The practice of opticianry under a trade name or service mark.

Section 37. Subsections (1) and (3) of section 484.007, Florida Statutes, as amended by section 30 of chapter 2024-243, Laws of Florida, are amended to read:

484.007 Licensure of opticians; permitting of optical establishments.—

(1) Any person desiring to practice opticianry must ~~shall~~ apply to the department, upon forms prescribed by it, to take a licensure examination. The department shall examine each applicant who ~~the board certifies~~ meets all of the following criteria:

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

~~board~~ finds the applicant ineligible to take the examination.

(b) Submits to background screening in accordance with s. 456.0135.

(c) Is not younger than 18 years of age.

(d) Is a graduate of an accredited high school or possesses a certificate of equivalency of a high school education.

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

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

(3) The department ~~board~~ shall certify ~~to the department~~ for licensure by endorsement any applicant who meets the requirements for licensure by endorsement under s. 456.0145.

Section 38. Section 484.008, Florida Statutes, is amended to read:

484.008 Renewal of license.—

(1) The department shall renew a license upon receipt of the renewal application and the fee set by the department ~~board~~ not to exceed $350.

(2) The department shall adopt rules establishing a procedure for the biennial renewal of licenses.

(3) The department ~~board~~ may by rule prescribe continuing education, not to exceed 20 hours biennially, as a condition for renewal of a license or certificate. The criteria for such programs or courses must ~~shall~~ be approved by the department ~~board~~. All education programs which contribute to the advancement, extension, or enhancement of professional skills and knowledge, whether conducted by a nonprofit or a profitmaking entity, are eligible for approval. The department ~~board~~ may establish by rule an application fee not to exceed $200 for anyone seeking approval to provide continuing education courses and may provide by rule for a fee not to exceed $200 for renewal of providership.

(4) The department ~~board~~ may excuse any licensee or group of licensees from the continuing education requirement, until the licensee or group of licensees is capable of fulfilling the continuing education requirement, if an unusual circumstance, emergency, or hardship prevented the licensee or group of licensees from complying with such requirement.

Section 39. Section 484.009, Florida Statutes, is amended to read:

484.009 Inactive status.—

(1) A license that has become inactive may be reactivated under s. 484.008 upon application to the department. The

department ~~board~~ shall prescribe by rule continuing education requirements as a condition of reactivating a license. The continuing education requirements for reactivating a license may not exceed 12 classroom hours for each year the license was inactive.

(2) The department ~~board~~ shall adopt ~~promulgate~~ rules relating to licenses which have become inactive and for the renewal of inactive licenses. The department ~~board~~ shall prescribe by rule a fee not to exceed $200 for the reactivation of an inactive license and a fee not to exceed $50 for the renewal of an inactive license.

Section 40. Section 484.011, Florida Statutes, is amended to read:

484.011 Supportive personnel.—No person other than a licensed optician may engage in the practice of opticianry, except that a licensed optician may delegate to nonlicensed supportive personnel those duties, tasks, and functions which fall within the purview of s. 484.002(2) ~~s. 484.002(3)~~. All such delegated acts shall be performed under the direct supervision of a licensed optician, who shall be responsible for all such acts performed by persons under her or his supervision.

Section 41. Subsection (2) of section 484.012, Florida Statutes, is amended to read:

484.012 Prescriptions; filing; duplication of prescriptions; duplication of lenses.—

(2) Upon request by the intended user of the prescribed lenses, spectacles, eyeglasses, contact lenses, or other optical devices, or by an agent of the intended user, the optician who fills the original prescription shall duplicate, on a form

prescribed by rule of the department ~~board~~, the original prescription. However, for medical reasons only, the prescribing allopathic or osteopathic physician or optometrist may, upon the original prescription, prohibit its duplication. Any duplication is ~~shall be~~ considered a valid prescription to be filled for a period of 5 years from the date of the original prescription, except that a contact lens prescription is ~~shall be~~ considered a valid prescription to be filled for a period of 2 years from the date of the original prescription.

Section 42. Paragraph (a) of subsection (1) of section 484.013, Florida Statutes, is amended to read:

484.013 Violations and penalties.—

(1) It is unlawful for any person:

(a) To make a false or fraudulent statement, either for herself or himself or for another person, in any application, affidavit, or statement presented to the department ~~board~~ or in any proceeding before the department ~~board~~.

Section 43. Paragraphs (a) and (m) of subsection (1) and subsections (2) and (3) of section 484.014, Florida Statutes, are amended to read:

484.014 Disciplinary actions.—

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

(a) Procuring, or attempting to procure, a license by misrepresentation, bribery, or fraud or through an error of the department ~~or the board~~.

(m) Willfully failing to report any person who the licensee knows is in violation of this part or of rules of the department ~~or the board~~.

(2) The department ~~board~~ may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

(3) The department may ~~board shall~~ not reinstate the license of an optician it has deemed unqualified until such time as it is satisfied that the optician has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of opticianry.

Section 44. Section 484.017, Florida Statutes, is amended to read:

484.017 Reciprocity.—In order to ensure that opticians licensed in this state may be licensed in other states, the department ~~board~~ may enter into reciprocity agreements with other states.

Section 45. Subsection (1) of section 484.041, Florida Statutes, is amended to read:

484.041 Definitions.—As used in this part, the term:

~~(1) "Board" means the Board of Hearing Aid Specialists.~~

Section 46. Section 484.042, Florida Statutes, is repealed.

Section 47. Section 484.043, Florida Statutes, is repealed.

Section 48. Section 484.044, Florida Statutes, is amended to read:

484.044 Authority to make rules.—

(1) The department may ~~board has authority to~~ adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the

provisions of this part conferring duties upon it.

(2) The department ~~board~~ shall adopt rules requiring that each prospective purchaser of a prescription hearing aid be notified by the attending hearing aid specialist, at the time of the initial examination for fitting and sale of a hearing aid, of telecoil, "t" coil, or "t" switch technology. The rules must ~~shall~~ further require that hearing aid specialists make available to prospective purchasers or clients information regarding telecoils, "t" coils, or "t" switches.

Section 49. Section 484.0445, Florida Statutes, is amended to read:

484.0445 Training program.—

(1) The department ~~board~~ shall establish by rule a training program for a minimum 6 months in length, which may include a department-approved ~~board-approved~~ home study course.

(2) A trainee shall perform the functions of a hearing aid specialist in accordance with department ~~board~~ rules only under the direct supervision of a licensed hearing aid specialist. The term "direct supervision" means that the sponsor is responsible for all work being performed by the trainee. The sponsor or a hearing aid specialist designated by the sponsor shall give final approval to work performed by the trainee and shall be physically present at the time the prescription hearing aid is delivered to the client.

(3) The department ~~board~~ may limit pursuant to rule the number of trainees a hearing aid specialist may supervise.

(4) The department ~~board~~ may, by rule, require that a licensed hearing aid specialist acting as a sponsor or as the designee of a sponsor under this section be certified by the

National Board for Certification in Hearing Instrument Sciences.

Section 50. Section 484.0447, Florida Statutes, is amended to read:

484.0447 Fees.—The department ~~board~~ shall by rule establish fees to be paid as follows:

(1) Examination application fee, not to exceed $150;

(2) Examination fee, not to exceed $175, which is refundable if the applicant is found to be ineligible to take the examination;

(3) Reexamination fee, not to exceed $175;

(4) Initial licensure fee, not to exceed $600;

(5) Trainee registration fee, not to exceed $100; and

(6) Biennial renewal fee, not to exceed $600.

Section 51. Subsections (2) and (3) of section 484.045, Florida Statutes, as amended by section 31 of chapter 2024-243, Laws of Florida, are amended to read:

484.045 Licensure by examination.—

(2) The department shall license each applicant who ~~the board certifies~~ meets all of the following criteria:

(a) Has completed the application form and remitted the required fees.

(b) Has submitted to background screening in accordance with s. 456.0135.

(c) Is of good moral character.

(d) Is 18 years of age or older.

(e) Is a graduate of an accredited high school or its equivalent.

(f)1. Has met the requirements of the training program; or

2.a. Has a valid, current license as a hearing aid

specialist or its equivalent from another state and has been actively practicing in such capacity for at least 12 months; or

b. Is currently certified by the National Board for Certification in Hearing Instrument Sciences and has been actively practicing for at least 12 months.

(g) Has passed an examination, as prescribed by department ~~board~~ rule.

(h) Has demonstrated, in a manner designated by rule of the department ~~board~~, knowledge of state laws and rules relating to the fitting and dispensing of prescription hearing aids.

(3) A person who fails the examination may make application for reexamination to the appropriate examining entity, as prescribed by department ~~board~~ rule.

Section 52. Section 484.047, Florida Statutes, is amended to read:

484.047 Renewal of license.—

(1) The department ~~board~~ by rule shall provide a method for the biennial renewal of a license.

(2) In addition to the other requirements for renewal provided in this section and by the department ~~board~~, the department shall renew a license upon receipt of the renewal application and the renewal fee. A licensee must maintain, if applicable, a certificate from a manufacturer or independent testing agent certifying that the testing room meets the requirements of s. 484.0501(6) and, if applicable, a certificate from a manufacturer or independent testing agent stating that all audiometric testing equipment used by the licensee has been calibrated acoustically to American National Standards Institute standards on an annual basis. Possession of an applicable

certificate is a prerequisite to renewal.

(3) A licensee shall notify the department ~~board~~ in writing of any change of address.

(4) The department ~~board~~ may adopt rules to require no more than 30 approved hours of mandatory continuing education for the renewal of a hearing aid specialist's license.

Section 53. Subsection (7) of section 484.0501, Florida Statutes, is amended to read:

484.0501 Minimal procedures and equipment.—

(7) The department ~~board~~ may prescribe the minimum procedures and equipment which must be used in the conducting of hearing assessments, and for the fitting and selling of prescription hearing aids, including equipment that will measure the prescription hearing aid's response curves to ensure that they meet the manufacturer's specifications. These procedures and equipment may differ from those provided in this section in order to take full advantage of devices and equipment which may hereafter become available and which are demonstrated to be of greater efficiency and accuracy. The department ~~board~~ shall adopt and enforce rules necessary to implement this subsection and subsection (6).

Section 54. Subsections (1) and (2) of section 484.0512, Florida Statutes, are amended to read:

484.0512 Thirty-day trial period; purchaser's right to cancel; notice; refund; cancellation fee; criminal penalty.—

(1) A person selling a prescription hearing aid in this state must provide the buyer with written notice of a 30-day trial period and money-back guarantee. The guarantee must permit the purchaser to cancel the purchase for a valid reason, as

defined by department ~~board~~ rule, within 30 days after receiving the prescription hearing aid, by returning the prescription hearing aid or mailing written notice of cancellation to the seller. If the prescription hearing aid must be repaired, remade, or adjusted during the 30-day trial period, the running of the 30-day trial period is suspended 1 day for each 24-hour period that the prescription hearing aid is not in the purchaser's possession. A repaired, remade, or adjusted prescription hearing aid must be claimed by the purchaser within 3 working days after notification of availability. The running of the 30-day trial period resumes on the day the purchaser reclaims the repaired, remade, or adjusted prescription hearing aid or on the fourth day after notification of availability, whichever occurs earlier.

(2) The department ~~board~~, in consultation with the Board of Speech-Language Pathology and Audiology, shall prescribe by rule the terms and conditions to be contained in the money-back guarantee and any exceptions thereto. Such rules must provide, at a minimum, that the charges for earmolds and service provided to fit the prescription hearing aid may be retained by the licensee. The rules must also set forth any reasonable charges to be held by the licensee as a cancellation fee. The terms and conditions of the guarantee, including the total amount available for refund, must be provided in writing to the purchaser before the signing of the contract.

Section 55. Paragraph (d) of subsection (1) and subsection (3) of section 484.053, Florida Statutes, are amended to read:

484.053 Prohibitions; penalties.—

(1) A person may not:

(d) Give false, incomplete, or forged evidence to the department ~~board or a member thereof~~ for the purposes of obtaining a license;

(3) If a person licensed under this part allows the sale of a prescription hearing aid by an unlicensed person not registered as a trainee or fails to comply with the requirements of s. 484.0445(2) relating to supervision of trainees, the department ~~board~~ must, upon determination of that violation, order the full refund of moneys paid by the purchaser upon return of the prescription hearing aid to the seller's place of business.

Section 56. Paragraphs (b) and (t) of subsection (1) and subsections (2) and (3) of section 484.056, Florida Statutes, are amended to read:

484.056 Disciplinary proceedings.—

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

(b) Attempting to procure a license to dispense hearing aids by bribery, by fraudulent misrepresentations, or through an error of the department ~~or the board~~.

(t) Failure to submit to the department ~~board~~ on an annual basis, or such other basis as may be provided by rule, certification of testing and calibration of audiometric testing equipment on the form approved by the department ~~board~~.

(2)(a) The department ~~board~~ may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s.

456.072(1).

(b) The department ~~board~~ shall revoke the license of any hearing aid specialist found guilty of canvassing as described in this section.

(3) The department shall reissue the license of a hearing aid specialist who has been disciplined upon certification by the department ~~board~~ that the hearing aid specialist has complied with all of the terms and conditions set forth in the final order.

Section 57. Subsection (4) of section 484.059, Florida Statutes, is amended to read:

484.059 Exemptions.—

(4) Section 484.053(1)(a) does not apply to registered trainees operating in compliance with this part and department ~~board~~ rules.

Section 58. Section 486.112, Florida Statutes, is amended to read:

486.112 Physical Therapy Licensure Compact.—The Physical Therapy Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

ARTICLE I

PURPOSE AND OBJECTIVES

(1) The purpose of the compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The compact preserves the regulatory authority of member states to protect public health

and safety through their current systems of state licensure. For purposes of state regulation under the compact, the practice of physical therapy is deemed to have occurred in the state where the patient is located at the time physical therapy is provided to the patient.

(2) The compact is designed to achieve all of the following objectives:

(a) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses.

(b) Enhance the states' ability to protect the public's health and safety.

(c) Encourage the cooperation of member states in regulating multistate physical therapy practice.

(d) Support spouses of relocating military members.

(e) Enhance the exchange of licensure, investigative, and disciplinary information between member states.

(f) Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

ARTICLE II

DEFINITIONS

As used in the compact, and except as otherwise provided, the term:

(1) "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders

pursuant to 10 U.S.C. chapter 1209 or chapter 1211.

(2) "Adverse action" means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

(3) "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a state's physical therapy licensing board. The term includes, but is not limited to, programs that address substance abuse issues.

(4) "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or physical therapist assistant in the remote state under its laws and rules.

(5) "Continuing competence" means a requirement, as a condition of license renewal, to provide evidence of participation in, and completion of, educational and professional activities relevant to the practice of physical therapy.

(6) "Data system" means the coordinated database and reporting system created by the Physical Therapy Compact Commission for the exchange of information between member states relating to licensees or applicants under the compact, including identifying information, licensure data, investigative information, adverse actions, nonconfidential information related to alternative program participation, any denials of applications for licensure, and other information as specified by commission rule.

(7) "Encumbered license" means a license that a physical therapy licensing board has limited in any way.

(8) "Executive board" means a group of directors elected or

appointed to act on behalf of, and within the powers granted to them by, the commission.

(9) "Home state" means the member state that is the licensee's primary state of residence.

(10) "Investigative information" means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

(11) "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a specific state.

(12) "Licensee" means an individual who currently holds an authorization from a state to practice as a physical therapist or physical therapist assistant.

(13) "Member state" means a state that has enacted the compact.

(14) "Party state" means any member state in which a licensee holds a current license or compact privilege or is applying for a license or compact privilege.

(15) "Physical therapist" means an individual licensed by a state to practice physical therapy.

(16)~~(15)~~ "Physical therapist assistant" means an individual licensed by a state to assist a physical therapist in specified areas of physical therapy.

(17)~~(16)~~ "Physical therapy" or "the practice of physical therapy" means the care and services provided by or under the direction and supervision of a licensed physical therapist.

(18)~~(17)~~ "Physical Therapy Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

(19)~~(18)~~ "Physical therapy licensing board" means the agency of a state which is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

(20)~~(19)~~ "Remote state" means a member state other than the home state where a licensee is exercising or seeking to exercise the compact privilege.

(21)~~(20)~~ "Rule" means a regulation, principle, or directive adopted by the commission which has the force of law.

(22)~~(21)~~ "State" means any state, commonwealth, district, or territory of the United States of America which regulates the practice of physical therapy.

ARTICLE III

STATE PARTICIPATION IN THE COMPACT

(1) To participate in the compact, a state must do all of the following:

(a) Participate fully in the commission's data system, including using the commission's unique identifier, as defined by commission rule.

(b) Have a mechanism in place for receiving and investigating complaints about licensees.

(c) Notify the commission, in accordance with the terms of the compact and rules, of any adverse action or the availability of investigative information regarding a licensee.

(d) Fully implement a criminal background check requirement, within a timeframe established by commission rule, which uses results from the Federal Bureau of Investigation

record search on criminal background checks to make licensure decisions in accordance with subsection (2).

(e) Comply with the commission's rules.

(f) Use a recognized national examination as a requirement for licensure pursuant to the commission's rules.

(g) Have continuing competence requirements as a condition for license renewal.

(2) Upon adoption of the compact, a member state has the authority to obtain biometric-based information from each licensee applying for a compact privilege and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. s. 534 and 34 U.S.C. s. 40316.

(3) A member state must grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise the compact privilege under the compact, a licensee must satisfy all of the following conditions:

(a) Hold a license in the home state.

(b) Not have an encumbrance on any state license.

(c) Be eligible for a compact privilege in all member states in accordance with subsections (4), (7), and (8).

(d) Not have had an adverse action against any license or compact privilege within the preceding 2 years.

(e) Notify the commission that the licensee is seeking the

compact privilege within a remote state.

(f) Meet any jurisprudence requirements established by the remote state in which the licensee is seeking a compact privilege.

(g) Report to the commission adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) The compact privilege is valid until the expiration date of the home license. The licensee must continue to meet the requirements of subsection (1) to maintain the compact privilege in a remote state.

(3) A licensee providing physical therapy in a remote state under the compact privilege must comply with the laws and rules of the remote state.

(4) A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any member state until the specific period of time for removal has ended and all fines are paid.

(5) If a home state license is encumbered, the licensee loses the compact privilege in any remote state until the following conditions are met:

(a) The home state license is no longer encumbered.

(b) Two years have elapsed from the date of the adverse action.

(6) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in any remote state.

(7) If a licensee's compact privilege in any remote state is removed, the licensee loses the compact privilege in all remote states until all of the following conditions are met:

(a) The specific period of time for which the compact privilege was removed has ended.

(b) All fines have been paid.

(c) Two years have elapsed from the date of the adverse action.

(8) Once the requirements of subsection (7) have been met, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in a remote state.

ARTICLE V

ACTIVE DUTY MILITARY PERSONNEL

AND THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may choose any of the following locations to designate his or her home state:

(1) Home of record.

(2) Permanent change of station location.

(3) State of current residence, if it is different from the home of record or permanent change of station location.

ARTICLE VI

ADVERSE ACTIONS

(1) A home state has exclusive power to impose adverse action against a license issued by the home state.

(2) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

(3) The compact does not override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation remain nonpublic if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

(4) A member state may investigate actual or alleged violations of the laws and rules for the practice of physical therapy committed in any other member state by a physical therapist or physical therapist assistant practicing under the compact who holds a license or compact privilege in such other member state.

(5) A remote state may do any of the following:

(a) Take adverse actions as set forth in subsection (4) of Article IV against a licensee's compact privilege in the state.

(b) Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party ~~member~~ state for the attendance and testimony of witnesses or for the production of evidence from

another party ~~member~~ state must be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service laws of the state where the witnesses or evidence is located.

(c) If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

(6)(a) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

ARTICLE VII

ESTABLISHMENT OF THE

PHYSICAL THERAPY COMPACT COMMISSION

(1) COMMISSION CREATED.—The member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

(a) The commission is an instrumentality of the member states.

(b) Venue is proper, and judicial proceedings by or against the commission must be brought solely and exclusively, in a court of competent jurisdiction where the principal office of

the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) The compact may not be construed to be a waiver of sovereign immunity.

(2) MEMBERSHIP, VOTING, AND MEETINGS.—

(a) Each member state has and is limited to one delegate selected by that member state's physical therapy licensing board to serve on the commission. The delegate must be a current member of the physical therapy licensing board who is a physical therapist, a physical therapist assistant, a public member, or the board administrator.

(b) A delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring on the commission must be filled by the physical therapy licensing board of the member state for which the vacancy exists.

(c) Each delegate is entitled to one vote with regard to the adoption of rules and bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

(d) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(e) The commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws.

(f) All meetings must be open to the public, and public

notice of meetings must be given in the same manner as required under the rulemaking provisions in Article IX.

(g) The commission or the executive board or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive board or other committees of the commission must discuss any of the following:

1. Noncompliance of a member state with its obligations under the compact.

2. The employment, compensation, or discipline of, or other matters, practices, or procedures related to, specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation against the commission, executive board, or other committees of the commission.

4. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.

5. An accusation of any person of a crime or a formal censure of any person.

6. Information disclosing trade secrets or commercial or financial information that is privileged or confidential.

7. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.

8. Investigatory records compiled for law enforcement purposes.

9. Information related to any investigative reports prepared by or on behalf of or for use of the commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact.

10. Matters specifically exempted from disclosure by federal or member state statute.

(h) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(i) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action must be identified in the minutes. All minutes and documents of a closed meeting must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(3) DUTIES.—The commission shall do all of the following:

(a) Establish the fiscal year of the commission.

(b) Establish bylaws.

(c) Maintain its financial records in accordance with the bylaws.

(d) Meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(4) POWERS.—The commission may do any of the following:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules have the force and effect of law and are binding in all member states.

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state

physical therapy licensing board to sue or be sued under applicable law is not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(e) Hire employees and elect or appoint officers; fix the compensation of, define the duties of, and grant appropriate authority to such individuals to carry out the purposes of the compact; and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(f) Accept any appropriate donations and grants of money, equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(g) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(h) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(i) Establish a budget and make expenditures.

(j) Borrow money.

(k) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in the compact and

the bylaws.

(l) Provide information to, receive information from, and cooperate with law enforcement agencies.

(m) Establish and elect an executive board.

(n) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of physical therapy licensure and practice.

(5) THE EXECUTIVE BOARD.—

(a) The executive board may act on behalf of the commission according to the terms of the compact.

(b) The executive board shall be composed of the following nine members:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. One ex officio, nonvoting member from the recognized national physical therapy professional association.

3. One ex officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

(c) The ex officio members shall be selected by their respective organizations.

(d) The commission may remove any member of the executive board as provided in its bylaws.

(e) The executive board shall meet at least annually.

(f) The executive board shall do all of the following:

1. Recommend to the entire commission changes to the rules or bylaws, compact legislation, fees paid by compact member states, such as annual dues, and any commission compact fee

charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractually or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Perform other duties as provided in the rules or bylaws.

(6) FINANCING OF THE COMMISSION.—

(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The commission may accept any appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) The commission may levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must total to an amount sufficient to cover the commission's annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based upon a formula to be determined by the commission, which shall adopt a rule binding upon all member states.

(d) The commission may not incur obligations of any kind before securing the funds adequate to meet such obligations; nor may the commission pledge the credit of any of the member

states, except by and with the authority of the member state.

(e) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION.—

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, whether personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, this paragraph may not be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the

scope of commission employment, duties, or responsibilities. However, this subsection may not be construed to prohibit any member, officer, executive director, employee, or representative of the commission from retaining his or her own counsel or to require the commission to defend such person if the actual or alleged act, error, or omission resulted from that person's intentional, willful, or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states.

(2) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable

as required by the rules of the commission, which data set must include all of the following:

(a) Identifying information.

(b) Licensure data.

(c) Investigative information.

(d) Adverse actions against a license or compact privilege.

(e) Nonconfidential information related to alternative program participation.

(f) Any denial of application for licensure, and the reason for such denial.

(g) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Investigative information in the system pertaining to a licensee in any member state must be available only to other party ~~member~~ states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license in a member state. Adverse action information pertaining to a licensee in any member state must be available to all other member states.

(5) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

(6) Any information submitted to the data system which is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE IX

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, such rule does not have further force and effect in any member state.

(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule by the commission, and at least 30 days before the meeting at which the rule will be considered and voted upon, the commission must file a notice of proposed rulemaking on all of the following:

(a) The website of the commission or another publicly accessible platform.

(b) The website of each member state physical therapy licensing board or another publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed date, time, and location of the meeting in which the rule or amendment will be considered and voted upon.

(b) The text of the proposed rule or amendment and the

reason for the proposed rule.

(c) A request for comments on the proposed rule or amendment from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before adoption of a proposed rule or amendment, the commission must allow persons to submit written data, facts, opinions, and arguments, which must be made available to the public.

(7) The commission must grant an opportunity for a public hearing before it adopts a rule or an amendment if a hearing is requested by any of the following:

(a) At least 25 persons.

(b) A state or federal governmental subdivision or agency.

(c) An association having at least 25 members.

(8) If a scheduled public hearing is held on the proposed rule or amendment, the commission must publish the date, time, and location of the hearing. If the hearing is held through electronic means, the commission must publish the mechanism for access to the electronic hearing.

(a) All persons wishing to be heard at the hearing must notify the executive director of the commission or another designated member in writing of their desire to appear and testify at the hearing at least 5 business days before the scheduled date of the hearing.

(b) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(c) All hearings must be recorded. A copy of the recording must be made available on request.

(d) This article may not be construed to require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(9) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(10) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public hearing.

(11) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this article are retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to do any of the following:

(a) Meet an imminent threat to public health, safety, or welfare.

(b) Prevent a loss of commission or member state funds.

(c) Meet a deadline for the adoption of an administrative rule established by federal law or rule.

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of the commission. The revision is subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the commission before the end of the notice period. If a challenge is not made, the revision takes effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE X
OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

(1) OVERSIGHT.—

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and take all actions necessary and appropriate to carry out the compact's purposes and intent. The provisions of the compact and the rules adopted pursuant thereto shall have standing as statutory law.

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(b) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities, or actions of the commission.

(c) The commission is entitled to receive service of process in any such proceeding and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission renders a judgment or an order void as to the commission, the compact, or the adopted rules.

(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION.—

(a) If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or the adopted rules, the commission must do all of the following:

1. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, and any other action to be taken by the commission.

2. Provide remedial training and specific technical assistance regarding the default.

(b) If a state in default fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states, and all rights, privileges, and benefits conferred by the compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(c) Termination of membership in the compact may be imposed

only after all other means of securing compliance have been exhausted. The commission shall give notice of intent to suspend or terminate a defaulting member state to the governor and majority and minority leaders of the defaulting state's legislature and to each of the member states.

(d) A state that has been terminated from the compact is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(e) The commission does not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting state.

(f) The defaulting state may appeal the action of the commission by petitioning the United States District Court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(3) DISPUTE RESOLUTION.—

(a) Upon request by a member state, the commission must attempt to resolve disputes related to the compact which arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(4) ENFORCEMENT.—

(a) The commission, in the reasonable exercise of its

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discretion, shall enforce the compact and the commission's rules.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) The remedies under this article are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XI

DATE OF IMPLEMENTATION OF THE

PHYSICAL THERAPY COMPACT

AND ASSOCIATED RULES; WITHDRAWAL;

AND AMENDMENTS

(1) The compact becomes effective on the date that the compact statute is enacted into law in the tenth member state. The provisions that become effective at that time are limited to the powers granted to the commission relating to assembly and the adoption of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary for the implementation and administration of the compact.

(2) Any state that joins the compact subsequent to the

commission's initial adoption of the rules is subject to the rules as they exist on the date that the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) Any member state may withdraw from the compact by enacting a statute repealing the same.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act before the effective date of withdrawal.

(4) The compact may not be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state which does not conflict with the provisions of the compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding upon any member state until it is enacted into the laws of all member states.

ARTICLE XII

CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to carry out the purposes thereof. The provisions of the compact are

severable, and if any phrase, clause, sentence, or provision of the compact is declared to be contrary to the constitution of any party ~~member~~ state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If the compact is held contrary to the constitution of any party ~~member~~ state, the compact remains in full force and effect as to the remaining party ~~member~~ states and in full force and effect as to the party ~~member~~ state affected as to all severable matters.

Section 59. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

20.43 Department of Health.—There is created a Department of Health.

(3) The following divisions of the Department of Health are established:

(g) Division of Medical Quality Assurance, which is responsible for the following boards and professions established within the division:

1. The Board of Acupuncture, created under chapter 457.

2. The Board of Medicine, created under chapter 458.

3. The Board of Osteopathic Medicine, created under chapter 459.

4. The Board of Chiropractic Medicine, created under chapter 460.

5. The Board of Podiatric Medicine, created under chapter 461.

6. Naturopathy, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.

8. The Board of Nursing, created under part I of chapter 464.

9. Nursing assistants, as provided under part II of chapter 464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

16. Respiratory therapy, as provided under part V of chapter 468.

17. Dietetics and nutrition practice, as provided under part X of chapter 468.

18. ~~The Board of~~ Athletic trainers, as provided ~~Training, created~~ under part XIII of chapter 468.

19. ~~The Board of~~ Orthotists and prosthetists, as provided ~~created~~ under part XIV of chapter 468.

20. Electrolysis, as provided under chapter 478.

21. The Board of Massage Therapy, created under chapter 480.

22. The Board of Clinical Laboratory Personnel, created under part I of chapter 483.

23. Medical physicists, as provided under part II of chapter 483.

24. ~~The Board of~~ Opticianry, as provided ~~created~~ under part I of chapter 484.

25. ~~The Board of~~ Hearing aid specialists, as provided ~~created~~ under part II of chapter 484.

26. The Board of Physical Therapy Practice, created under chapter 486.

27. The Board of Psychology, created under chapter 490.

28. School psychologists, as provided under chapter 490.

29. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

30. Emergency medical technicians and paramedics, as provided under part III of chapter 401.

Section 60. Paragraph (a) of subsection (5) of section 943.031, Florida Statutes, is amended to read:

943.031 Florida Violent Crime and Drug Control Council.—

(5) DUTIES OF COUNCIL.—Subject to funding provided to the department by the Legislature, the council shall provide advice and make recommendations, as necessary, to the executive director of the department.

(a) The council may advise the executive director on the feasibility of undertaking initiatives which include, but are not limited to, the following:

1. Establishing a program that provides grants to criminal justice agencies that develop and implement effective violent crime prevention and investigative programs and which provides grants to law enforcement agencies for the purpose of drug control, criminal gang, and illicit money laundering investigative efforts or task force efforts that are determined

by the council to significantly contribute to achieving the state's goal of reducing drug-related crime, that represent significant criminal gang investigative efforts, or that represent a significant illicit money laundering investigative effort~~, or that otherwise significantly support statewide strategies developed by the Statewide Drug Policy Advisory Council established under s. 397.333~~, subject to the limitations provided in this section. The grant program may include an innovations grant program to provide startup funding for new initiatives by local and state law enforcement agencies to combat violent crime or to implement drug control, criminal gang, or illicit money laundering investigative efforts or task force efforts by law enforcement agencies, including, but not limited to, initiatives such as:

a. Providing enhanced community-oriented policing.

b. Providing additional undercover officers and other investigative officers to assist with violent crime investigations in emergency situations.

c. Providing funding for multiagency or statewide drug control, criminal gang, or illicit money laundering investigative efforts or task force efforts that cannot be reasonably funded completely by alternative sources and that significantly contribute to achieving the state's goal of reducing drug-related crime, that represent significant criminal gang investigative efforts, or that represent a significant illicit money laundering investigative effort~~, or that otherwise significantly support statewide strategies developed by the Statewide Drug Policy Advisory Council established under s. 397.333~~.

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2. Expanding the use of automated biometric identification systems at the state and local levels.

3. Identifying methods to prevent violent crime.

4. Identifying methods to enhance multiagency or statewide drug control, criminal gang, or illicit money laundering investigative efforts or task force efforts that significantly contribute to achieving the state's goal of reducing drug-related crime, that represent significant criminal gang investigative efforts, or that represent a significant illicit money laundering investigative effort~~, or that otherwise significantly support statewide strategies developed by the Statewide Drug Policy Advisory Council established under s. 397.333~~.

5. Enhancing criminal justice training programs that address violent crime, drug control, illicit money laundering investigative techniques, or efforts to control and eliminate criminal gangs.

6. Developing and promoting crime prevention services and educational programs that serve the public, including, but not limited to:

a. Enhanced victim and witness counseling services that also provide crisis intervention, information referral, transportation, and emergency financial assistance.

b. A well-publicized rewards program for the apprehension and conviction of criminals who perpetrate violent crimes.

7. Enhancing information sharing and assistance in the criminal justice community by expanding the use of community partnerships and community policing programs. Such expansion may include the use of civilian employees or volunteers to relieve

law enforcement officers of clerical work in order to enable the officers to concentrate on street visibility within the community.

Section 61. Paragraph (a) of subsection (1) of section 943.042, Florida Statutes, is amended to read:

943.042 Violent Crime Investigative Emergency and Drug Control Strategy Implementation Account.—

(1) There is created a Violent Crime Investigative Emergency and Drug Control Strategy Implementation Account within the Department of Law Enforcement Operating Trust Fund. The account shall be used to provide emergency supplemental funds to:

(a) State and local law enforcement agencies that are involved in complex and lengthy violent crime investigations, or matching funding to multiagency or statewide drug control or illicit money laundering investigative efforts or task force efforts that significantly contribute to achieving the state's goal of reducing drug-related crime or~~,~~ that represent a significant illicit money laundering investigative effort~~, or that otherwise significantly support statewide strategies developed by the Statewide Drug Policy Advisory Council established under s. 397.333~~;

Section 62. Paragraph (a) of subsection (5) of section 1004.6495, Florida Statutes, is amended to read:

1004.6495 Florida Postsecondary Comprehensive Transition Program and Florida Center for Students with Unique Abilities.—

(5) CENTER RESPONSIBILITIES.—The Florida Center for Students with Unique Abilities is established within the University of Central Florida. At a minimum, the center shall:

(a) Disseminate information to students with disabilities and their parents, including, but not limited to:

1. Education programs, services, and resources that are available at eligible institutions.

2. Supports, accommodations, technical assistance, or training provided by eligible institutions~~, the advisory council established pursuant to s. 383.141,~~ and regional autism centers established pursuant to s. 1004.55.

3. Mentoring, networking, and employment opportunities.

Section 63. The Department of Health shall conduct a comprehensive study to evaluate and determine the efficiency of boards and councils within the department. The department shall submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 15, 2025.

Section 64. This act shall take effect July 1, 2025.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 7, 2025

I respectfully request that **Senate Bill #1270**, relating to Department of Health, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Jay Collins
Florida Senate, District 14

File signed original with committee office

S-020 (03/2004)

Tab 10

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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4/1/25
Meeting Date

Health Policy
Committee

1270
Bill Number or Topic

* 275506
Amendment Barcode (if applicable)

Name Katherine Henry

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Email

Ormond Beach FL 32176
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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4-1-25
Meeting Date

Health Policy
Committee

1270
Bill Number or Topic

275506 (1270)
Amendment Barcode (if applicable)

Name Maya Hahn

Phone 909-289-3406

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Street

Email Maya@REACTforhope.org

Merritt Island, FL 32952
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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April 01, 2025
Meeting Date

Health Policy
Committee

1270
Bill Number or Topic

2755506
Amendment Barcode (if applicable)

Name Karoline Stancik

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

PLEASE CHECK ONE OF THE FOLLOWING:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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4/1/2025
Meeting Date

health policy
Committee

670
Bill Number or Topic

375506
Amendment Barcode (if applicable)

Name Sofia Zaronias Phone (757)946-0971

Address 848 riverside dr. Email gzaronias@gmail.com
Street

TS R 34689
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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April 1, 2025
Meeting Date

HEATH Policy
Committee

~~1207~~ 1270
Bill Number or Topic

2775506
Amendment Barcode (if applicable)

Name Ko Rosins

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Street

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City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

4/1/25
Meeting Date

Healthy Policy
Committee

SB 1270
Bill Number or Topic

275506
Amendment Barcode (if applicable)

Name Joe Anne Hart

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Street

Email jahart@floridadental.org

Tall, FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Dental Association

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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Senate professional staff conducting the meeting

H-1-25
Meeting Date

Health Policy
Committee

1270
Bill Number or Topic

275506
Amendment Barcode (if applicable)

Name Lynne Hartmann

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Address 325 Banyan Wy
Street

Mel Bch, FL 32951
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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4.1.25
Meeting Date

Health Policy
Committee

1270
Bill Number or Topic

275506
Amendment Barcode (if applicable)

Name Bailey Cotter

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Street

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Pinellas Park, FL 33782
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

Tab 10

The Florida Senate

APPEARANCE RECORD

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

04/01/25
Meeting Date

Health Policy
Committee

SB 1270
Bill Number or Topic

978704 ~~[illegible]~~
Amendment Barcode (if applicable)

Name Ryan Bradley

Phone 850-681-6788

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Street

Email

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

Florida Academy of Physician Assistants

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S-001 (08/10/2021)

Tab 16 1270

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting 978704

04/04/25
Meeting Date

Health Policy
Committee

SB [redacted]
Bill Number or Topic

[redacted]
Amendment Barcode (if applicable)

Name Corinne Mixon

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Email cmixon@gmail.com

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Academy of Physician Assistants

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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April 1, 2025
Meeting Date

Health Policy
Committee

1270
Bill Number or Topic

Amendment Barcode (if applicable)

Name Noah Adamson

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Email juliecladamson@gmail.com

Address 200 Northgrove Drive
Street

Merritt Island FL 32953
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

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The Florida Senate

APPEARANCE RECORD

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April 1, 2025
Meeting Date

Health Policy
Committee

1270
Bill Number or Topic

Amendment Barcode (if applicable)

Name Julie Adamson

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Email ~~jcdal~~ juliecladamson@gmail.com

Merritt Island FL 32953
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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4-1-25
Meeting Date

Health Policy
Committee

1270
Bill Number or Topic

[redacted]
Amendment Barcode (if applicable)

Name Maija Hahn

Phone 909-289-3406

Address 132 Rainbow St.
Street

Email Maija@REACTforhope.org

Merritt Is., FL 32952
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

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☐ I am a registered lobbyist, representing:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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1/APR/25
Meeting Date

HHS
Committee

SB 1270
Bill Number or Topic

Amendment Barcode (if applicable)

Name Ted Macie

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Jacksonville FL 32206
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

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S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 772
INTRODUCER:	Education Pre-K - 12 Committee and Senator Calatayud
SUBJECT:	Diabetes Management in Schools
DATE:	March 31, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Sabitsch	Bouck	ED	**Fav/CS**
2.	Morgan	Brown	HP	**Favorable**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 772 authorizes a school district or charter school to acquire and maintain undesignated glucagon to treat students with diabetes who experience a hypoglycemic emergency or whose prescribed glucagon is not available onsite or has expired. Specifically, the bill:

- Provides definitions related to diabetes management in schools.
- Allows a school district or charter school to obtain a prescription for glucagon from a county health department or health care provider.
- Allows a licensed pharmacist to dispense undesignated glucagon to a school district or charter school with a prescription.
- Allows a school district or charter school to enter into arrangements with manufacturers or suppliers of glucagon to obtain products.
- Requires undesignated glucagon obtained by school districts and charter schools to be stored in a specific manner.
- Requires that a school district or charter school employee or agent trained in the administration of glucagon be responsible for the storage, maintenance, and administration of undesignated glucagon.
- Requires certain notifications immediately after administration of undesignated glucagon.
- Releases school district and charter school employees, as well as certain health care practitioners, from civil and criminal liability related to glucagon administration or prescribing, respectively. Additionally, health care practitioners and pharmacists are not subject to regulatory discipline regarding licensure under the bill.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Types of Diabetes

Diabetes is a chronic heath condition that affects how the human body turns food into energy. The human body breaks down most of the carbohydrates humans eat into glucose[1] and releases it into the bloodstream, thereby increasing blood glucose. Such an increase should signal the pancreas[2] to release the hormone insulin, which acts as a catalyst to allow the body's cells to metabolize the glucose and convert it to energy, or to convert the glucose into forms suitable for short-term or long-term storage.

For individuals with diabetes, the body does not make enough insulin or cannot use the insulin as well as it should, which results in too much blood glucose remaining in the bloodstream. Over time, this can lead to serious health problems, such as heart disease, vision loss, kidney disease, vascular disease, and other maladies. Such outcomes are often known as long-term complications of diabetes.

There are three basic types of diabetes:
- Type 1 diabetes
- Type 2 diabetes
- Gestational diabetes

Type 1 Diabetes

Type 1 diabetes is thought to be caused by an autoimmune reaction in which the body's immune system attacks and destroys the cells in the pancreas that normally produce insulin. Roughly 5 to 10 percent of people with diabetes have Type 1. Symptoms of Type 1 often develop quickly. It is usually diagnosed in children, teens, and young adults. Someone with Type 1 diabetes must take insulin, usually through subcutaneous injection, on a regular basis to survive, one or more times per day. Currently, Type 1 diabetes can neither be prevented nor cured.[3]

Type 2 Diabetes

With Type 2 diabetes, the body does not use insulin well and cannot keep blood glucose at normal levels. About 90 to 95 percent of people with diabetes have Type 2. It develops over many years and is usually diagnosed in overweight, middle-aged adults, although it can sometimes manifest in adolescents and young adults. Type 2 diabetes can often be prevented or delayed, or even eliminated altogether, with healthy lifestyle changes, such as losing weight,

---

[1] Glucose is the simplest type of carbohydrate (chemical formula $C_6H_{12}O_6$), and all carbohydrates consumed as food must be broken down into glucose before the body can metabolize them.
[2] The pancreas is an organ located in the abdomen. It plays an essential role in converting food into fuel. The pancreas has two main functions: an exocrine function that helps in digestion and an endocrine function that regulates blood glucose. *See*: https://columbiasurgery.org/pancreas/pancreas-and-its-functions (last visited Mar. 27, 2025).
[3] Centers for Disease Control and Prevention, *What Is Diabetes?, available at*: https://www.cdc.gov/diabetes/basics/diabetes.html (last visited Mar. 27, 2025).

eating healthy food, and exercising regularly.[4] Type 2 diabetes is usually treated with oral medications but can require insulin injections in some cases.

Gestational Diabetes

Gestational diabetes develops in pregnant women who have never had diabetes. If a woman has gestational diabetes, her baby could be at higher risk for health problems. Gestational diabetes usually goes away after the baby is born. However, it increases the mother's risk for Type 2 diabetes later in life and the baby is more likely to have obesity as a child or teen and develop Type 2 diabetes later in life.[5]

Hypoglycemia

Individuals with diabetes can experience hypoglycemia.[6] Hypoglycemia is a condition in which an individual's blood glucose level is lower than the standard range. Hypoglycemia is often related to diabetes treatment, and the most common reason for low blood glucose is a side effect of medications used to treat diabetes, usually insulin. If blood glucose levels become too low, hypoglycemia signs and symptoms can include:[7]

- Looking pale.
- Shakiness.
- Sweating.
- Headache.
- Hunger or nausea.
- An irregular or fast heartbeat.
- Fatigue.
- Irritability or anxiety.
- Difficulty concentrating.
- Dizziness or lightheadedness.
- Tingling or numbness of the lips, tongue, or cheek.

As hypoglycemia worsens, signs and symptoms can include:[8]

- Disorientation, confusion, and unusual behavior, such as the inability to complete routine tasks.
- Loss of coordination.
- Slurred speech.
- Blurry vision, double vision, or tunnel vision.

Severe hypoglycemia may cause loss of consciousness, and, in the most severe cases, seizures, brain damage, or death.[9]

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[4] *Id.*
[5] U.S. Centers for Disease Control, *Diabetes Basics*, https://www.cdc.gov/diabetes/about/index.html (last visited Mar. 27, 2025).
[6] Mayo Clinic, *Hypoglycemia- Overview*, https://www.mayoclinic.org/diseases-conditions/hypoglycemia/symptoms-causes/syc-20373685 (last visited Mar. 27, 2025).
[7] *Id.*
[8] *Id.*
[9] *Id.*

Insulin and Glucagon

Insulin and glucagon work together to regulate blood glucose levels and ensure that the human body has a constant supply of energy. Insulin and glucagon are hormones that help regulate the levels of blood glucose in the body.[10]

Insulin is needed for the body to use glucose as energy. When blood glucose is not needed immediately, it is stored as glycogen (short term storage)[11] or fat (long-term storage). Glucagon signals cells to convert stored glycogen back into glucose when the body needs immediate energy or when blood glucose begins falling. Insulin and glucagon work together to balance blood glucose levels, keeping them in the range that the body requires.

However, when a diabetic has introduced too much insulin into his or her body through injection or has not eaten enough carbohydrates to correspond to the injected insulin, blood glucose can drop dangerously low, and in such dangerous cases, the body is unable to convert glycogen back into glucose rapidly enough to counteract that effect.

There are also manufactured forms of glucagon that can be taken as an injection or nasal powder (dry nasal spray). This form of glucagon may be used in emergencies when a diabetic has very low blood glucose and is experiencing moderate or severe hypoglycemia. The glucagon triggers the liver to rapidly release glucose that had been stored as glycogen, which then raises blood glucose and should partially or fully mitigate hypoglycemia.[12]

Prevalence of Diabetes

The National Diabetes Statistic Report provides up-to-date information on the prevalence and incidence of diabetes and prediabetes, risk factors for complication, acute and long-term complication, deaths, and costs. Highlights of reported statistics include the following:[13]

- In 2021 there were 29.7 million people of all ages, or 8.9 percent of the U.S. population, who had diagnosed diabetes.
- In 2021 there were 352,000 children and adolescents younger than age 20 who had diagnosed diabetes, including 304,000 with Type 1 diabetes.

Diabetes in Florida

The Florida Diabetes Advisory Council (DAC) is mandated and authorized by s. 385.203, F.S, to guide a statewide comprehensive approach to diabetes prevention, diagnosis, education, care, treatment, impact, and costs. The DAC serves as the advisory unit to the Department of Health

[10] Healthline, *How Insulin and Glucagon Work*, https://www.healthline.com/health/diabetes/insulin-and-glucagon (last visited Mar. 27, 2025).
[11] Glycogen is the stored form of glucose that's made up of many connected glucose molecules. When the human body does not immediately need glucose for energy, it stores glucose primarily in muscles and the liver as glycogen for later use. *See*: https://my.clevelandclinic.org/health/articles/23509-glycogen (last visited Mar. 27, 2025)
[12] *Id.*
[13] U.S. Centers for Disease Control, *National Diabetes Statistical Report*, https://www.cdc.gov/diabetes/php/data-research/index.html (last visited Mar. 27, 2025).

(DOH), other governmental agencies, professional and other organizations, as well as the general public.

The DAC makes specific recommendations to the State Surgeon General regarding the public health aspects of the prevention and control of diabetes. In January of each odd numbered year, the DAC, in conjunction with the DOH, is required to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The items highlighted below are from the most recent report dated January 2025.[14]

- Florida has seen an increase in the percentage of adults diagnosed with diabetes from 8.2 percent in 2002, to 12.2 percent in 2022. This is higher than the national rate of 11.6 percent. It is estimated that 38 million adults in the U.S. have diabetes, with Florida accounting for over 2.1 million of those diagnosed.[15]
- In 2022-2023, in a population of 2,851,846 pre-kindergarten through 12-grade students, there were 6,568 reported students with Type 1 diabetes (0.23 percent) and 1,139 students with Type 2 diabetes (0.04 percent) in Florida public schools, for a total of 7,707 (0.27 percent) students living with diabetes. Of these students, 5,833 (0.20 percent) received glucose monitoring assistance, 4,821 (0.17 percent) received carbohydrate-counting assistance, and 5,197 (0.18 percent) received assistance with insulin administration at schools throughout the school year.[16]
- It is estimated that in 2017, the total cost of diabetes in Florida was $24.8 billion, with $19.3 billion attributed to direct medical expenses for diagnosed diabetes and $5.5 billion attributed to indirect costs from loss of productivity due to the condition. The average annual medical expenditures among individuals with diabetes are 2.6 times higher than among individuals who have not been diagnosed with diabetes.[17]

Florida students with diabetes are covered under Section 504 of the federal Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability in programs or activities that receive federal financial assistance from the U.S. Department of Education.[18] The Section 504 regulation defines an "individual with handicaps" as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. The key factor in determining whether a person is considered an "individual with handicaps" covered by Section 504 is whether the physical or mental impairment results in a substantial limitation of one or more major life activities. Major life activities, as defined in the regulation, include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.[19]

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[14] Florida Department of Health, Florida Diabetes Advisory Council, *Legislative Report* (Jan. 2025), *available at* https://www.floridahealth.gov/provider-and-partner-resources/dac/_documents/2025-dac-report.pdf.
[15] Florida Department of Health, Florida Diabetes Advisory Council, *Legislative Report* (Jan. 2025), *available at* https://www.floridahealth.gov/provider-and-partner-resources/dac/_documents/2025-dac-report.pdf, at 8.
[16] Florida Department of Health, Florida Diabetes Advisory Council, *Legislative Report* (Jan. 2025), *available at* https://www.floridahealth.gov/provider-and-partner-resources/dac/_documents/2025-dac-report.pdf, at 15.
[17] Florida Department of Health, Florida Diabetes Advisory Council, *Legislative Report* (Jan. 2025), *available at* https://www.floridahealth.gov/provider-and-partner-resources/dac/_documents/2025-dac-report.pdf, at 20.
[18] U.S. Department of Education, *The Civil Rights of Students With Hidden Disabilities and Section 504*, https://www.ed.gov/laws-and-policy/individuals-disabilities/section-504/hidden-disabilities (last visited Mar. 27, 2025).
[19] *Id.*

Diabetes may be considered a hidden disability under Section 504 that includes such conditions and diseases as specific learning disabilities, diabetes, epilepsy, allergy or chronic illnesses. A chronic illness involves a recurring and long-term disability such as diabetes, heart disease, kidney and liver disease, high blood pressure, or ulcers.[20] Students with diabetes may require the development of a Diabetes Medical Management Plan (DMMP) in order to meet the meet the needs of the student. The DMMP contains medical orders and all aspects of routine and emergency diabetes care. This plan works hand in hand with an Individual Health Plan (IHP) to describe how diabetes care as prescribed in the DMMP will be delivered in the school.[21]

III. Effect of Proposed Changes:

CS/SB 772 modifies s. 1002.20, F.S., to support students with diabetes by allowing school districts and charter schools to request a prescription for glucagon that would enable schools to acquire and maintain a supply of undesignated (not assigned to a person) glucagon for the purposes of treating a student who experiences a hypoglycemic emergency or whose prescribed glucagon is not available or has expired. The bill provides definitions for the following:

- Authorized health care practitioner, which includes a licensed allopathic or osteopathic physician, physician assistant, or advanced practice registered nurse.
- Participating school, which is a public school maintaining a supply of undesignated glucagon under the bill.
- Undesignated glucagon, which is a glucagon rescue therapy that is prescribed in the name of a public school or school district.

The bill allows a licensed pharmacist to dispense undesignated glucagon to a school district or charter school and permits school districts and charter schools to enter into agreements with manufacturers or suppliers of glucagon to obtain favorable pricing. The bill also permits school districts and charter schools to seek donations or grants in order to obtain glucagon.

The bill specifies that undesignated glucagon must be stored in a location so that it is readily accessible to the school nurse of other school personnel who have been trained to administer glucagon to students and requires that a trained individual be responsible for storage, maintenance, and administration of glucagon stocked by a school.

The bill requires that the undesignated glucagon to be administered to a student with diabetes as prescribed in the student's diabetes management plan. Following the administration of undesignated glucagon to a student, the bill requires specific notifications and requires an employee of the public school to call for emergency assistance.

[20] *Id.*
[21] American Diabetes Association, *Helping the Student with Diabetes Succeed- A Guide for School Personnel*, *available at* https://diabetes.org/sites/default/files/2023-10/School-guide-final-11-16-22.pdf. (last visited Mar. 27, 2025).

The bill provides immunity from civil or criminal liability from the administration of glucagon by certain school district or charter school employees. Additionally, the bill provides immunity from civil or criminal liability to authorized health care practitioners and pharmacists who, acting in good faith and exercising reasonable care, prescribe or dispense glucagon under the bill, as well as providing that such persons are not subject to adverse action regarding professional licensing statute or rule.

The bill requires the State Board of Education, in cooperation with the Department of Health, to adopt rules to implement the provisions in the bill.

The bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 1002.20 of the Florida Statutes.

IX. Additional Information:

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

CS by Education Pre-K – 12 on March 17, 2025:
The committee substitute:

- Defines terms related to authorized personnel, schools, and rescue therapy.
- Authorizes and provides requirements for a school district or school to acquire and maintain a supply of undesignated glucagon for treatment of students.
- Allows a school district or school to engage a wholesale distributor of manufacturer of glucagon to obtain a stock of glucagon and sets requirements for accepting donated or transferred glucagon.
- Allows a school district to request a prescription of glucagon from a county health department and permits an authorized health care practitioner to prescribe glucagon in the name of the school district or school.
- Provides requirements for the administration of the undesignated glucagon to students experiencing a hypoglycemic emergency and provides criminal and civil immunity to certain employees, authorized health care practitioners and pharmacists. Protects certain authorized healthcare practitioners and pharmacists from discipline and other adverse actions under any professional licensure statute or rule.

B. Amendments:

None.

By the Committee on Education Pre-K - 12; and Senator Calatayud

581-02507-25 2025772c1

A bill to be entitled

An act relating to diabetes management in schools; amending s. 1002.20, F.S.; defining terms; authorizing a school district or public school to acquire and maintain a supply of undesignated glucagon; requiring that undesignated glucagon be stored in a secure location that is immediately accessible; authorizing a school district or public school to enter into arrangements with a manufacturer or supplier to obtain glucagon free of charge or at a fair market or reduced price; authorizing a school district or public school to accept donated or transferred glucagon that meets certain requirements; authorizing a school district or public school to obtain monetary donations or apply for grants to purchase glucagon; authorizing a school district or public school to request a prescription for glucagon from a county health department; authorizing a licensed health care practitioner to prescribe glucagon in the name of a school district or public school; authorizing a licensed pharmacist to dispense glucagon pursuant to such prescription; requiring a participating school to make available undesignated glucagon to be administered as ordered in a student's diabetes medical management plan or health care practitioner's orders; requiring an employee to call for emergency assistance and provide parental notification after the administration of glucagon; requiring the State Board of Education to adopt rules; providing certain persons and entities with immunity

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

from civil and criminal liability under certain circumstances; providing an effective date.

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

Section 1. Paragraph (j) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(j) *Diabetes management.*—

1. As used in this paragraph, the term:

a. "Authorized health care practitioner" means a physician licensed under chapter 458 or chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464.

b. "Participating school" means a public school which maintains a supply of undesignated glucagon pursuant to this paragraph.

c. "Undesignated glucagon" means a glucagon rescue therapy approved by the United States Food and Drug Administration that does not require reconstitution for the treatment of severe hypoglycemia in a dosage form that can be rapidly administered to the patient in an emergency, including prefilled injectable or nasally administered glucagon, and is prescribed in the name

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of a public school or school district pursuant to this paragraph.

2. A school district may not restrict the assignment of a student who has diabetes to a particular school on the basis that the student has diabetes, that the school does not have a full-time school nurse, or that the school does not have trained diabetes personnel. Diabetic students whose parent and physician provide their written authorization to the school principal may carry diabetic supplies and equipment on their person and attend to the management and care of their diabetes while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities to the extent authorized by the parent and physician and within the parameters set forth by State Board of Education rule. The written authorization shall identify the diabetic supplies and equipment that the student is authorized to carry and shall describe the activities the child is capable of performing without assistance, such as performing blood-glucose level checks and urine ketone testing, administering insulin through the insulin-delivery system used by the student, and treating hypoglycemia and hyperglycemia.

a. The State Board of Education, in cooperation with the Department of Health, shall adopt rules to encourage every school in which a student with diabetes is enrolled to have personnel trained in routine and emergency diabetes care. The State Board of Education, in cooperation with the Department of Health, shall also adopt rules for the management and care of diabetes by students in schools that include provisions to protect the safety of all students from the misuse or abuse of

diabetic supplies or equipment.

b. A school district, county health department, and public-private partner, and the employees and volunteers of those entities, shall be indemnified by the parent of a student authorized to carry diabetic supplies or equipment for any and all liability with respect to the student's use of such supplies and equipment pursuant to this paragraph.

3. A school district or public school may acquire and maintain a supply of undesignated glucagon for the purpose of treating a student with diabetes experiencing a hypoglycemic emergency. Undesignated glucagon must be stored in a secure location on the school's premises that is immediately accessible to a school nurse or other school personnel trained to administer glucagon pursuant to this paragraph. Undesignated glucagon must be stored in accordance with the manufacturer's instructions.

a. A school district or public school may acquire and stock a supply of glucagon from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer as defined in s. 499.003 for glucagon at fair market, free, or reduced prices pursuant to a prescription issued in accordance with this section.

b. A school district or public school may accept donated or transferred glucagon if it is new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration. A school district or public school may also obtain monetary donations or apply for grants to purchase glucagon.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

c. A school district or public school may request a prescription for glucagon from a county health department.

4. An authorized health care practitioner may prescribe glucagon in the name of a school district or public school for use in accordance with this section, and a licensed pharmacist may dispense glucagon pursuant to a prescription issued in the name of a school district or public school for use in accordance with this paragraph.

5. A participating school shall make available undesignated glucagon that is able to be administered as ordered in a student's diabetes medical management plan or health care practitioner's orders.

6. A school nurse or trained school personnel shall administer glucagon to students only if such school nurse or trained school personnel has successfully completed training and believe in good faith that the student is experiencing a hypoglycemic emergency.

7. Immediately after undesignated glucagon has been administered to a student, an employee of the public school shall call for emergency assistance, notify the school nurse, and notify the student's parent or guardian or emergency contact.

8. The State Board of Education, in cooperation with the Department of Health, shall adopt rules to implement the provisions of this paragraph.

9. Notwithstanding any other provision of law to the contrary, a school nurse or school personnel of a school district trained in the administration of glucagon who administers or attempts to administer glucagon in compliance

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with this section and s. 768.13 and the school district that employs the school nurse or the trained school personnel are immune from civil or criminal liability as a result of such administration or attempted administration of glucagon.

10.a. An authorized health care practitioner, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of prescribing glucagon in accordance with this section.

b. A dispensing health care practitioner or pharmacist, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of dispensing glucagon in accordance with this section.

Section 2. This act shall take effect July 1, 2025.

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The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 18th, 2025

I respectfully request that **Senate Bill #772**, relating to Diabetes Management in Schools, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Alexis Calatayud

Senator Alexis Calatayud
Florida Senate, District 38

File signed original with committee office

S-020 (03/2004)

Tab 11

The Florida Senate

APPEARANCE RECORD

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

4/1/25
Meeting Date

Health Policy
Committee

772
Bill Number or Topic

Amendment Barcode (if applicable)

Name Doug Bell

Phone 850 205 9000

Address 119 S. Monroe
Street

Email doug.bell@mhdfirm.com

TLH FL 32312
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

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

Florida Chapter of the American Academy of Pediatrics

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

4/1/25
Meeting Date

Health Policy
Committee

SB 772
Bill Number or Topic

Amendment Barcode (if applicable)

Name Amanda Fraser

Phone 850 556 1401

Email

Address
Street

City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: American Diabetes Association

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

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

S-001 (08/10/2021)

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 998
INTRODUCER:	Health Policy Committee and Senator Calatayud
SUBJECT:	Physician Assistant and Advanced Practice Registered Nurse Services
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.			AHS	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 998 authorizes an advanced practice registered nurse (APRNs) providing hospice care pursuant to a written protocol with a licensed physician to file a certificate of death or fetal death, to certify the cause of death, and to correct information on a permanent certificate of death or fetal death.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Vital Statistics and Death Certificates

Florida law requires the registration of all deaths and fetal deaths with the Department of Health (DOH) through the Office of Vital Statistics. Section 382.008, F.S., governs the filing of death and fetal death certificates. The funeral director who first assumes custody of the body is responsible for electronically filing the certificate.[1] In the absence of a funeral director, current law permits a physician, physician assistant, advanced practice registered nurse registered for autonomous practice (A-APRN), or the district medical examiner to file the certificate.[2]

[1] Section 382.008(2)(a), F.S.
[2] *Id.*

The "medical certification of cause of death" must be completed by the decedent's primary or attending practitioner or the district medical examiner within 72 hours of receipt of the death certificate.[3] Under current law, a "primary or attending practitioner" is defined as a physician, PA, or an A-APRN who treated the decedent during the 12 months preceding death.[4] These practitioners are also authorized to note corrections on permanent death or fetal death certificates.[5]

Hospice Care Teams and Plans of Care

Part IV, of chapter 400, F.S., establishes requirements for hospice programs. A hospice is a centrally coordinated program offering a continuum of palliative and supportive care for terminally ill patients and their families.[6] Admission to hospice care requires a diagnosis of terminal illness by a physician licensed under ch. 458 or ch. 459, F.S., and the patient's informed consent.[7] For purposes of hospice programs, a "terminal illness" is defined as a condition with a life expectancy of 12 months or less if the illness runs its normal course.[8]

Hospice programs are required to employ multidisciplinary hospice care teams responsible for establishing and reviewing patients' plans of care and supervising the delivery of hospice services. A hospice care team may also withhold or withdraw cardiopulmonary resuscitation (CPR) if presented with a do-not-resuscitate (DNR) order executed under s. 401.45, F.S.[9] Pursuant to s. 400.6105, F.S., each "hospice care team"[10] must include, at a minimum:

- A physician licensed under ch. 458 or ch. 459, F.S.;
- A nurse licensed under part I, of ch. 464, F.S.;
- A social worker; and
- A pastoral or other counselor.

APRNs, A-APRNs, and PAs[11]

Advanced practice registered nurses (APRNs) are regulated under part I, of ch. 464, F.S., the Nurse Practice Act. The Florida Board of Nursing establishes eligibility criteria for APRN licensure and regulatory standards for APRN practice. APRNs may only perform medical acts that are directly related to the performance of authorized nursing or medical acts performed pursuant to a physician's protocol. The scope of practice includes administering medications and treatments as prescribed or authorized by a licensed practitioner, starting and managing IVs, and monitoring and responding to patient reactions, provided these actions occur within a protocol agreement with a supervising physician or dentist licensed under chs. 458, 459, or 466, F.S.

[3] Section 382.008(3), F.S.
[4] *Id.*
[5] Section 382.008(5), F.S.
[6] Section 400.601, F.S.
[7] Section 400.6095(2), F.S.
[8] Section 400.601(10), F.S.,
[9] Section 400.6095(8), F.S.
[10] *See also* s. 400.601(4), F.S.
[11] Department of Health, Senate Bill 998 Legislative Analysis (Mar. 28, 2025) (on file with the Senate Committee on Health Policy).

Section 464.0123, F.S., establishes minimum qualifications for an APRN to register for autonomous practice. An autonomous APRN (A-APRN) is not subject to supervision by a physician or required to work under a protocol. These practitioners may only provide care in primary care, which includes: physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions, services such as physical and mental health promotion, disease prevention, patient education, and treatment of acute and chronic conditions, including behavioral and mental health conditions.[12]

Autonomous APRNs are also authorized to admit and discharge hospice patients and manage their care independently. As of February 2025, there are 64,953 licensed APRNs in Florida, including 13,470 with the autonomous designation.

A physician assistant (PA) is a health care practitioner who practices under the direct or indirect supervision of an allopathic or osteopathic physician. PAs are authorized to perform medical services such as conducting physical exams, diagnosing and treating illness, counseling on preventive care, assisting in surgery, and prescribing medication. Supervising physicians may only delegate tasks and procedures to a PA that are within the physician's own scope of practice, and the supervising physician must ensure that the PA is qualified to perform any delegated tasks. PAs must disclose to patients that they are not physicians and must inform patients of their right to consult the supervising physician before a prescription is issued or dispensed. PAs are authorized to sign certain medical documents, including death certificates, Baker Act commitments, and school physicals.

III. Effect of Proposed Changes:

Section 1 amends s. 382.008, F.S., to expand the list of individuals authorized to file a certificate of death or fetal death and to note corrections on permanent certificates. Under current law, in the absence of a funeral director, a physician, physician assistant, A-APRN, or the district medical examiner may file the certificate. The bill expands this authority to include APRNs providing hospice care pursuant to a written protocol with a licensed physician. These practitioners are responsible for completing the medical certification of cause of death within 72 hours of receipt of the death or fetal death certificate and signing it to the best of their knowledge and belief.

Similarly, under the bill, APRNs providing hospice care under a written protocol with a licensed physician may correct information on a permanent certificate of death or fetal death, alongside funeral directors, physicians, PAs, A-APRNs, and medical examiners.

Section 2 provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[12] Rule 64B9-4.001(12), F.A.C

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 382.008 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:
The CS removes provisions from the underlying bill that would have authorized both autonomous APRNs providing hospice care pursuant to a written protocol with a physician, and PAs, to develop and review a hospice plan of care as a "primary or attending practitioner." The CS also removes provisions that would have authorized an autonomous APRN providing hospice care pursuant to a written protocol with a physician to sign a DNR order.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

475642

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Calatayud) recommended the following:

Senate Amendment (with title amendment)

Delete lines 93 - 183.

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

And the title is amended as follows:

Delete lines 7 - 13

and insert:

fetal death; providing

By Senator Calatayud

38-00556B-25 2025998__

A bill to be entitled

An act relating to physician assistant and advanced practice registered nurse services; amending s. 382.008, F.S.; revising who may file a certificate of death or fetal death; revising who may note corrected information on a permanent certificate of death or fetal death; amending s. 400.601, F.S.; revising the definition of "hospice care team"; defining the term "primary or attending practitioner"; amending s. 400.6095, F.S.; revising the roles and responsibilities of the plan of care team in hospice programs; amending s. 401.45, F.S.; revising who may sign a patient's order not to resuscitate; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) and subsections (3) and (5) of section 382.008, Florida Statutes, are amended to read:

382.008 Death, fetal death, and nonviable birth registration.—

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall electronically file the certificate of death or fetal death. In the absence of the funeral director, the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, advanced practice registered nurse providing hospice care pursuant to a written protocol with a licensed physician, or other person in attendance at or after

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the death or the district medical examiner of the county in which the death occurred or the body was found shall electronically file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from a legally authorized person as described in s. 497.005 or the best qualified person or source available. The medical certification of cause of death must be furnished to the funeral director, either in person or via certified mail or electronic transfer, by the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, advanced practice registered nurse providing hospice care pursuant to a written protocol with a licensed physician, or medical examiner responsible for furnishing such information. For fetal deaths, the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, advanced practice registered nurse providing hospice care pursuant to a written protocol with a licensed physician, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(3) Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made available to the funeral director by the decedent's primary or attending practitioner or, if s. 382.011 applies, the district medical examiner of the county in which the death occurred or the body was found. The primary or attending practitioner or the medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge and belief. As used in this section, the term "primary or attending practitioner" means

a physician, a physician assistant, an ~~or~~ advanced practice registered nurse registered under s. 464.0123, or an advanced practice registered nurse providing hospice care pursuant to a written protocol with a licensed physician, who treated the decedent through examination, medical advice, or medication during the 12 months preceding the date of death.

(a) The department may grant the funeral director an extension of time upon a good and sufficient showing of any of the following conditions:

1. An autopsy is pending.

2. Toxicology, laboratory, or other diagnostic reports have not been completed.

3. The identity of the decedent is unknown and further investigation or identification is required.

(b) If the decedent's primary or attending practitioner or the district medical examiner of the county in which the death occurred or the body was found indicates that he or she will sign and complete the medical certification of cause of death but will not be available until after the 5-day registration deadline, the local registrar may grant an extension of 5 days. If a further extension is required, the funeral director must provide written justification to the registrar.

(5) A permanent certificate of death or fetal death, containing the cause of death and any other information that was previously unavailable, shall be registered as a replacement for the temporary certificate. The permanent certificate may also include corrected information if the items being corrected are noted on the back of the certificate and dated and signed by the funeral director, physician, physician assistant, advanced

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practice registered nurse registered under s. 464.0123, advanced practice registered nurse providing hospice care pursuant to a written protocol with a licensed physician, or district medical examiner of the county in which the death occurred or the body was found, as appropriate.

Section 2. Present subsection (10) of section 400.601, Florida Statutes, is redesignated as subsection (11), a new subsection (10) is added to that section, and subsection (4) is amended, to read:

400.601 Definitions.—As used in this part, the term:

(4) "Hospice care team" means an interdisciplinary team of qualified professionals and volunteers who, in consultation with the patient, the patient's family, and the patient's primary or attending practitioner ~~physician~~, collectively assess, coordinate, and provide the appropriate palliative and supportive care to hospice patients and their families.

(10) "Primary or attending practitioner" means a physician licensed under chapter 458 or 459, a physician assistant licensed under s. 458.347 or s. 459.022, or an advanced practice registered nurse registered under s. 464.0123 pursuant to a written protocol with a supervising physician.

Section 3. Present subsections (7), (8), and (9) of section 400.6095, Florida Statutes, are redesignated as subsections (8), (9), and (10), respectively, a new subsection (7) is added to that section, and subsections (2), (5), (6), and present subsection (8) of that section are amended, to read:

400.6095 Patient admission; assessment; plan of care; discharge; death.—

(2) Admission to a hospice program shall be made upon a

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diagnosis and prognosis of terminal illness by the patient's primary or attending practitioner ~~a physician licensed pursuant to chapter 458 or chapter 459~~ and shall be dependent on the expressed request and informed consent of the patient.

(5) Each hospice, in collaboration with the patient and the patient's primary or attending practitioner ~~physician~~, shall prepare and maintain a plan of care for each patient, and the care provided to a patient must be in accordance with the plan of care. The plan of care shall be made a part of the patient's medical record and shall include, at a minimum:

(a) Identification of the primary caregiver, or an alternative plan of care in the absence of a primary caregiver, to ensure that the patient's needs will be met.

(b) The patient's diagnosis, prognosis, and preferences for care.

(c) Assessment of patient and family needs, identification of the services required to meet those needs, and plans for providing those services through the hospice care team, volunteers, contractual providers, and community resources.

(d) Plans for instructing the patient and family in patient care.

(e) Identification of the nurse designated to coordinate the overall plan of care for each patient and family.

(f) A description of how needed care and services will be provided in the event of an emergency.

(6) The hospice shall provide an ongoing assessment of the patient and family needs, update the plan of care to meet changing needs, coordinate the care provided with the patient's primary or attending practitioner ~~physician~~, and document the

services provided.

(7) The care a patient receives while he or she is enrolled in hospice or receiving palliative care may be managed by a primary or attending practitioner. Management of the care includes, but is not limited to, admission, transfer, and discharge from hospice enrollment or a hospice inpatient facility.

(9)~~(8)~~ The hospice care team may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Hospice staff shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and applicable rules. The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a practitioner ~~physician~~ from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

Section 4. Paragraph (a) of subsection (3) of section 401.45, Florida Statutes, is amended to read:

401.45 Denial of emergency treatment; civil liability.—

(3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician or physician assistant is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician, ~~or~~ physician

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

assistant, or advanced practice registered nurse providing hospice care pursuant to a written protocol with a licensed physician, and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

Section 5. This act shall take effect July 1, 2025.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 2, 2025

I respectfully request that **Senate Bill #998**, relating to Physician Assistant and Advanced Practice Registered Nure Services, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Alexis Calatayud

Senator Alexis Calatayud
Florida Senate, District 38

File signed original with committee office

S-020 (03/2004)

Tab 12c

The Florida Senate

APPEARANCE RECORD

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

4.1.2025
Meeting Date

Health Policy
Committee

998
Bill Number or Topic

475642
Amendment Barcode (if applicable)

Name Paul Ledford

Phone 850.321.4617

Address 817 N. Gadsden Street
Street

Email paul@floridahospices.org

Tallahassee FL 32303
City State Zip

for: amendment + bill

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Hospice and Palliative Care Association

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

04/01/2025
Meeting Date

Health Policy
Committee

SB 998
Bill Number or Topic

Amendment Barcode (if applicable)

Name Edda Fernandez

Phone 954-850-7262

Address 215 Monroe Street 603
Street

Email ifernandez@aarp.org

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

4/1/2025
Meeting Date

Health Policy
Committee

SB 998
Bill Number or Topic

Amendment Barcode (if applicable)

Name JACK CORY

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Street

Email JACKCORY@AHCentral.com

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: The Florida Nursing Assoc.

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

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

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

S-001 (08/10/2021)

TWD 12

The Florida Senate

APPEARANCE RECORD

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

4-1-25
Meeting Date

Health Policy
Committee

998
Bill Number or Topic

Amendment Barcode (if applicable)

Name Daniel Martinez

Phone 305-240-2917

Address 107 E College Ave
Street

Email DMartinez@AFPHQ.org

TLH FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Americans for Prosperity

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

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1412
INTRODUCER:	Senator Calatayud
SUBJECT:	Home Health Care Services
DATE:	March 31, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AHS	
3.			RC	

I. Summary:

SB 1412 amends several sections of the Florida statutes related to home health agencies (HHA) to:

- Allow one administrator to manage multiple HHAs with identical controlling interests, regardless of where they are located;
- Remove a requirement in current law that initial visits, service evaluation visits, and discharge visits must be conducted by a direct employee of the HHA; and
- Rework the Excellence in Home Health Program to require the Agency for Health Care Administration (AHCA) to adopt standards that are adaptable to all types of HHAs, regardless of payor type, patient population, or service designations.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Home Health Agencies

A HAA is an organization that provides medical services to an individual in the individual's home or place of residence.[1] Home health services include:

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services;
- Homemaker and companion services;
- Dietetics and nutrition; and
- Medical supplies.[2]

[1] Section 400.462, F.S.
[2] *Id.*

HHAs are licensed and regulated by the AHCA. Currently, there are 2,646 licensed HHAs in Florida.[3]

Home Health Agency Personnel

HHAs provide skilled nursing services and unskilled home health aide services.

Skilled nursing services must be provided by a registered nurse, licensed practical nurse, speech-language pathologist, or audiologist, or by an occupational therapist, respiratory therapist, or physical therapist.[4]

Unskilled services may be provided by home health aides and certified nursing assistants (CNAs). These services, which must be delegated by and under the supervision of a registered nurse, include:

- Assisting the patient or client with personal hygiene, ambulation, eating, dressing, toileting, physical transfer, and other personal care activities; and
- Assisting the patient with self-administration of medication.[5]

Direct Employees and Contract Employees

HHA personnel can be either direct employees[6] or persons under contract with a HHA.[7] However, the initial admission visit, all service evaluation visits, and the discharge visit must be provided by a licensed registered nurse directly employed by the home health agency.[8] Services provided by individuals under contract with a home health agency must be monitored and managed by the admitted home health agency.[9]

Administrators

An HHA administrator must be a direct employee, who is a licensed physician, physician assistant, or registered nurse, or have at least one year of supervisory or administrative experience in home health care or in a hospital, nursing home, or an assisted living facility.[10]

Current law authorizes an administrator to manage more than one, and up to five, home health agencies, if all five home health agencies have identical controlling interests and are located within one agency geographic service area, or within an immediately contiguous county.[11]

---

[3] Florida Health Finder, Facility/Provider, Search by Location, Home Health Agency, *available at* https://quality.healthfinder.fl.gov/Facility-Provider/HHA?&type=1 (last visited Mar. 28, 2025).
[4] *Supra* n. 1
[5] Rule 59A-8.002, F.A.C.
[6] Section 400.462(10), F.S. "Direct employee" means an employee for whom one of the following entities pays withholding taxes: a home health agency; a management company that has a contract to manage the home health agency on a day-to-day basis; or an employee leasing company that has a contract with the home health agency to handle the payroll and payroll taxes for the home health agency.
[7] *Supra* n. 1
[8] Section 400.487, F.S.
[9] *Id.*
[10] *Supra* n. 1
[11] Section 400.476, F.S.

The Excellence in Home Health Program

The Excellence in Home Health Program was created by the Legislature in 2020 to issue award designations to high-performing home health agencies. A home health agency that is awarded under the Program can use the designation in their advertising and marketing.

A home health agency must meet the certain criteria to be eligible to apply for the award designation. The home health agency must have been actively licensed and operating for at least 24 months and have had no licensure denials, revocations, or serious deficiencies during the preceding 24 months. To qualify for the award, an applicant must:

- Provide targeted in-service training for employees;
- Demonstrate evidence of employee satisfaction through information obtained directly from employees;
- Demonstrate evidence of a stable workforce by submitting evidence of an effective recruitment and retention program, keeping turnover rates below 50 percent or ensuring that at least 50 percent of staff members have been employed for a minimum of one year;
- Develop, implement, and maintain a continuous quality improvement (CQI) program consistent with national industry standards;
- Develop quantitative metric tools to capture and calculate data related to the CQI program's components, which must demonstrate that the applicant ranks at or above the 95th percentile statewide for:
  - Patient improvement in the activities of daily living;
  - Prevention of medication errors;
  - Patient or client willingness to recommend the home health agency to family and friends;
  - Patient or client satisfaction with the communication and interaction between the home health agency and the patient or client;
  - Prevention of unplanned patient or client emergency care for wound infections;
  - Prevention of unplanned patient or client admission or readmission to an acute care hospital.[12]

III. Effect of Proposed Changes:

SB 1412 amends s. 400.476, F.S., to allow a HHA administrator to manage multiple HHAs regardless of their location as long as they have identical controlling interests.

The bill amends s. 400.487, F.S., to remove a requirement that, when nursing services are ordered, the HHA must provide the initial admission visit, all service evaluation visits, and the discharge visit by a direct employee.

The bill also amends s. 400.52, F.S., to rework the Excellence in Home Health Program to require that the AHCA must adopt standards that are adaptable to all types of HHAs, regardless of payor type, patient population, or service designation. The bill replaces current requirements for the program with new requirements specifying that such standards must include, at a minimum:

[12] Section 400.52, F.S.

- Patient or client satisfaction, including communication and willingness to recommend the HHA.
- Service excellence, including:
  - For skilled providers, service excellence includes outcomes related to clinical improvements, such as reducing adverse events, unplanned emergency care, and hospitalizations.
  - For nonskilled providers, service excellence includes contributions to daily living support, personal care quality, and overall client well-being 71.
- Workforce stability and development, including employee satisfaction, retention rates, and training initiatives appropriate to the home health agency's services.
- Innovation in care delivery, such as implementing new technologies, caregiver education programs, or tailored approaches to meeting patient or client needs.

The bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 400.476, 400.487, and 400.52.

IX. Additional Information:

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Calatayud

38-01268-25 20251412__

A bill to be entitled

An act relating to home health care services; amending s. 400.476, F.S.; deleting geographical limitations on the home health agencies that an administrator may manage at any given time; amending s. 400.487, F.S.; deleting a requirement that, under certain circumstances, a home health agency provide the initial admission visit, service evaluation visits, and the discharge visit to admitted patients by a direct employee; amending s. 400.52, F.S.; revising the eligibility criteria for awards under the Excellence in Home Health Program; providing an effective date.

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

Section 1. Paragraph (a) of subsection (1) of section 400.476, Florida Statutes, is amended to read:

400.476 Staffing requirements; notifications; limitations on staffing services.—

(1) ADMINISTRATOR.—

(a) An administrator may manage only one home health agency, except that an administrator may manage up to five home health agencies if all five home health agencies have identical controlling interests as defined in s. 408.803 ~~and are located within one agency geographic service area or within an immediately contiguous county~~. If the home health agency is licensed under this chapter and is part of a retirement community that provides multiple levels of care, an employee of

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

the retirement community may administer the home health agency and up to a maximum of four entities licensed under this chapter or chapter 429 which all have identical controlling interests as defined in s. 408.803. An administrator shall designate, in writing, for each licensed entity, a qualified alternate administrator to serve during the administrator's absence.

Section 2. Subsection (5) of section 400.487, Florida Statutes, is amended to read:

400.487 Home health service agreements; physician's, physician assistant's, and advanced practice registered nurse's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.—

(5) ~~When nursing services are ordered, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit by a direct employee.~~ Nursing services provided by direct employees of and individuals ~~others~~ under contractual arrangements to a home health agency must be monitored and managed by the admitting home health agency. The admitting home health agency is fully responsible for ensuring that all care provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

Section 3. Paragraph (a) of subsection (2) of section 400.52, Florida Statutes, is amended to read:

400.52 Excellence in Home Health Program.—

(2)(a) The agency shall adopt rules establishing criteria for the program which must include, at a minimum, standards that are adaptable to all types of home health agencies, regardless

of the payor type, patient population, or service designation. The criteria must also include, at a minimum, ~~meeting~~ standards relating to:

1. Patient or client satisfaction, including communication and willingness to recommend the home health agency.

2. Service excellence.

a. For skilled providers, service excellence includes outcomes related to clinical improvements, such as reducing adverse events, unplanned emergency care, and hospitalizations.

b. For nonskilled providers, service excellence includes contributions to daily living support, personal care quality, and overall client well-being ~~Patients requiring emergency care for wound infections~~.

3. Workforce stability and development, including employee satisfaction, retention rates, and training initiatives appropriate to the home health agency's services ~~Patients admitted or readmitted to an acute care hospital~~.

4. Innovation in care delivery, such as implementing new technologies, caregiver education programs, or tailored approaches to meeting patient or client needs ~~Patient improvement in the activities of daily living~~.

~~5. Employee satisfaction.~~

~~6. Quality of employee training.~~

~~7. Employee retention rates.~~

~~8. High performance under federal Medicaid electronic visit verification requirements.~~

Section 4. This act shall take effect July 1, 2025.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 7, 2025

I respectfully request that **Senate Bill #1412**, relating to Home Health Care Services, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Alexis Calatayud

Senator Alexis Calatayud
Florida Senate, District 38

File signed original with committee office

Tab 13

The Florida Senate

APPEARANCE RECORD

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

4/1/2025
Meeting Date

Senate Health Policy
Committee

SB 1412
Bill Number or Topic

Amendment Barcode (if applicable)

Name Denise Bellville

Phone 727-735-3971

Address 817 N. Gadsden St
Street

Email dbellville@homecarefla.org

Tallahassee FL 32303
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Home Care Association of Fla

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

4/1/25
Meeting Date

S. Health Policy
Committee

1412
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jennifer Ungru

Phone 850-419-5100

Address
Street

Email jungru@joneswalker.com

City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Home Care Association of America

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

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1800
INTRODUCER:	Health Policy Committee and Senator Calatayud
SUBJECT:	Parkinson's Disease Research Funding
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1800 creates s. 1004.4352, F.S., to establish the Parkinson's Disease Research Board (board), as well as the Consortium for Parkinson's Disease Research (consortium) within the University of South Florida (USF). The board is established to direct the operations of the consortium, and the consortium exists to conduct rigorous scientific research and disseminate such research.

The bill establishes the composition of the board, the terms for board appointments, when the board must meet, the manner in which the board conducts business.

The bill requires that board members serve without compensation; however, board members are entitled to receive reimbursement for travel expenses in accordance with s. 112.061, F.S.

The bill requires the consortium be administered by a director appointed by the board and establishes specific duties for the director.

The bill requires the board to adopt a plan for Parkinson's disease research annually and to award funds to members of the consortium to perform research consistent with the plan.

The bill requires the board to issue a report to the Governor and the Legislature on research projects, research findings, community outreach initiatives, and future plans for the consortium by October 15 of each year.

The bill also creates a non-statutory section of the Laws of Florida to require funds be allocated a certain way, subject to appropriations from the General Appropriations Act.

The bill provides that the section may be cited as the "Parkinson's Disease Research Act."

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Parkinson's Disease

Parkinson's disease is a movement disorder of the nervous system[1] that worsens over time. Although Parkinson's disease cannot be cured, medications may help control and improve symptoms.[2]

Parkinson's disease is very common overall, ranking second among age-related degenerative brain diseases. It is also the most common motor (movement-related) brain disease. Experts estimate that it affects at least 1 percent of people over the age of 60 worldwide.[3]

Parkinson's disease is not fatal, but the symptoms and effects are often contributing factors to death. The average life expectancy for Parkinson's disease in 1967 was a little under 10 years. Since then, the average life expectancy has increased by about 55 percent, rising to more than 14.5 years. That, combined with the fact that Parkinson's diagnosis is much more likely after age 60, means this condition does not often affect the life expectancy by more than a few years.[4]

Parkinson's Disease Symptoms & Complications

Parkinson's disease symptoms can be different for everyone. Early symptoms may be mild and may go unnoticed. Symptoms often begin on one side of the body, then affect both sides as the disease progresses. Symptoms are usually worse on one side than the other.[5]

Parkinson's disease symptoms may include:[6]

- Tremors – Rhythmic shaking that usually begins in the hands or fingers. Sometimes a tremor begins in the foot or jaw, or an individual may rub their thumb and forefinger back and forth,

---

[1] The nervous system is a network of nerve cells that controls many parts of the body, including movement. *See* Mayo Clinic, *Parkinson's Disease, available at* https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055#:~:text=Parkinson's%20disease%20is%20a%20movement,a%20foot%20or%20the%20jaw. (last visited Mar. 30, 2025).

[2] Mayo Clinic, *Parkinson's Disease, available at* https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055#:~:text=Parkinson's%20disease%20is%20a%20movement,a%20foot%20or%20the%20jaw. (last visited Mar. 30, 2025).

[3] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Mar. 30, 2025).

[4] *Id.*

[5] *Supra* note 2.

[6] *Id.*

also known as a pill-rolling tremor. The hand may tremble when at rest or when under stress. Some individuals notice less shaking when doing some sort of task or moving around.

- Bradykinesia (slow movement) – Parkinson's disease may slow movement, making simple tasks more difficult. It can be challenging to get out of a chair, shower, or get dressed. The disease may cause less facial expression and make it difficult to blink.
- Rigid muscles – Parkinson's disease can cause stiff muscles in any part of the body. Muscles may feel tense and painful, and arm movements may become short and jerky.
- Poor posture and balance – Parkinson's disease may cause posture to become stooped, and an individual may experience falls or problems with balance.
- Loss of automatic movements – Parkinson's disease may lessen an individual's ability to make certain movements that typically are accomplished without thinking, including blinking, smiling, or swinging arms while walking.
- Speech changes – The disease may result in soft or quick speech, slurring, or hesitation prior to speaking. Speech may become flat or monotone, without typical speech patterns.
- Writing changes – Trouble writing and writing that appears cramped and small are a sign of the disease.
- Nonmotor symptoms – These may include depression; anxiety; constipation; sleep problems, including acting out dreams; the need to urinate often; trouble smelling; problems thinking and with memory; feeling very tired; blood pressure changes; and pain or cramps in muscles and joints.

Individuals with Parkinson's disease may have treatable complications, including:[7]

- Trouble thinking clearly – Parkinson's disease can affect memory, language, and reasoning skills. The disease can also lead to dementia or other conditions that affect thinking. These complications usually occur later in the disease's progression, and typically medications have only a modest benefit in managing symptoms.
- Emotional changes and depression – Some people feel irritable and concerned early in the course of Parkinson's disease, experiencing depression and anxiety. Medications and other treatments can assist with these changes.
- Trouble swallowing and chewing – Late-stage Parkinson's disease affects the muscles in the mouth causing trouble swallowing and chewing, which can lead to a nutrient deficiency. The collection of food or saliva in the mouth can also pose a choking hazard or cause drooling.
- Sleep problems and sleep disorders – Individuals with Parkinson's disease may wake often during the night, have nightmares, and fall asleep during the day.
- Rapid eye movement sleep behavior disorder – This involves acting out dreams, and medications and other therapies may help improve sleep.

[7] *Id.*

Causes of Parkinson's Disease

Parkinson's disease causes a specific area of the brain, the basal ganglia,[8] to deteriorate. As this area deteriorates, the ability to control the areas regulated by this portion of the brain decreases. Researchers have uncovered that Parkinson's disease causes a major shift in brain chemistry.[9]

Under normal circumstances, the brain uses chemicals known as neurotransmitters to control how brain cells (neurons) communicate with each other. With Parkinson's disease, an individual does not have enough dopamine, one of the most important neurotransmitters.[10]

When the brain sends activation signals telling the muscles to move, it fine-tunes the movements using cells that require dopamine. A lack of dopamine causes slowed movements and tremors, symptoms of Parkinson's disease.[11]

As Parkinson's disease progresses, the symptoms expand and intensify. Later stages of the disease often affect brain functions, causing dementia-like symptoms and depression.[12]

The cause of Parkinson's disease is unknown, but several factors seem to play a role, including:[13]

- Genes – Specific genetic changes are linked to Parkinson's disease, but these are rare unless many family members have been diagnosed with the disease.
- Environmental factors – Exposure to certain toxins or other environmental factors may increase the risk of later Parkinson's disease. One example is 1-methyl-4-phenyl-1,2,3,6-tetrahydropyridine (MPTP), a substance that can be found in illegal drugs and is sometimes sold illegally as "synthetic heroin." Other examples include pesticides and contaminated well-water used for drinking; however, no environmental factor has been identified as a definitive cause.

Many changes occur in the brains of individuals with Parkinson's disease. Researchers are studying the changes which include:[14]

- The presence of Lewy bodies – Clumps of proteins in the brain, called Lewy bodies, are associated with Parkinson's disease and researchers believe these proteins hold an important clue to the cause of the disease.
- Alpha-synuclein found within Lewy bodies – Alpha-synuclein is a protein found in all Lewy bodies. It occurs in a clumped form that cells cannot break down. This is currently an

[8] The basal ganglia are a cluster of nuclei found deep to the neocortex of the brain. It has a multitude of functions associated with reward and cognition but is primarily involved in motor control. In particular, the basal ganglia are considered to be a gate-keeping mechanism for the initiation of motor movement, effectively choosing which actions to allow and which actions to inhibit. See National Institutes of Health, National Library of Medicine, National Center for Biotechnology Information, *Neuroanatomy, Basal Ganglia, available at* *https://www.ncbi.nlm.nih.gov/books/NBK537141/#:~:text=The%20basal%20ganglia%20is%20a,primarily%20involved%20in%20motor%20control*. (last visited Mar. 30, 2025).
[9] *Supra* note 3.
[10] *Id*.
[11] *Id*.
[12] *Id*.
[13] *Supra* note 2.
[14] *Id*.

important focus among Parkinson's disease researchers. Alpha-synuclein has been found in the spinal fluid of individuals who later have Parkinson's disease.

- Altered mitochondria – Mitochondria are powerhouse compartments inside cells that create most of the body's energy. Changes to mitochondria can cause cell damage and are often observed in the brains of individuals with Parkinson's disease.

Parkinson's Disease Risk Factors

Risk factors for Parkinson's disease include:[15]

- Age – The risk of Parkinson's disease increases with age. Usually, it starts around age 50 or older. The average age of onset is around age 70. Parkinson's disease can occur in younger adults, but it is rare. When individuals younger than age 50 are diagnosed with the disease, it is known as early-onset Parkinson's disease.
- Genetics – The risk of developing Parkinson's Disease increases if one or more first-degree relatives, such as parents or siblings, have been diagnosed with the disease. However, familial Parkinson's disease is only attributed to about 10 percent of all cases.[16]
- Sex – Men are more likely to develop Parkinson's disease than women.
- Exposure to toxins – Ongoing exposure to herbicides and pesticides may slightly increase the risk of developing Parkinson's disease.

Parkinson's Disease Prevention

Since the cause of Parkinson's disease is unknown, there are no proven ways to prevent it. However, research shows that some factors may help protect against it, including:[17]

- Exercise – Aerobic exercise has been linked to a lower risk of Parkinson's disease.
- Caffeine - Some studies show a link between drinking caffeinated beverages, such as coffee and green tea, may lower the risk of developing Parkinson's disease.
- Medicines – Some medications, such as ibuprofen and statins,[18] have been linked to a lower risk of the disease.

Parkinson's Disease Diagnosis and Tests

A biomarker is a biological molecule found in blood, other body fluids, or tissues that are a sign of a normal or abnormal process, or of a condition or disease. A biomarker may be used to see how well the body responds to a treatment for a disease or condition.[19]

Biomarker testing is a method to look for genes, proteins, and other substances (biomarkers or tumor markers) that can provide information about cancer and other conditions. Biomarkers are substances in the body that can give researchers and doctors information about a person's health.

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[15] *Id*.
[16] *Supra* note 3.
[17] *Id*.
[18] Statins are drugs that can lower cholesterol. *See* Mayo Clinic, *Statins: Are these cholesterol-lowering drugs right for you?, available at* https://www.mayoclinic.org/diseases-conditions/high-blood-cholesterol/in-depth/statins/art-20045772#:~:text=Statins%20are%20drugs%20that%20can,of%20heart%20disease%20and%20stroke. (last visited Mar. 30, 2025).
[19] National Institutes of Health, National Cancer Institute, *Biomarker Testing for Cancer Treatment, available at* https://www.cancer.gov/about-cancer/treatment/types/biomarker-testing-cancer-treatment (last visited Mar. 30, 2025).

For example, high cholesterol is a biomarker of heart disease. Currently, the use of biomarkers is in the beginning stages to help diagnose Parkinson's disease.[20]

Diagnosing Parkinson's disease is mostly a clinical process, meaning it relies heavily on a health care provider examining the symptoms, asking questions, and reviewing medical history. Some diagnostic and lab tests are possible, but these are usually needed to rule out other conditions or certain causes; however, most lab tests are not necessary unless the patient is unresponsive to treatment for Parkinson's disease, which can indicate another condition.[21]

When health care providers suspect Parkinson's disease or need to rule out other conditions, various imaging and diagnostic tests are possible, including:[22]

- Blood tests;
- Computed tomography (CT) scans;[23]
- Genetic testing;
- Magnetic resonance imaging (MRI);[24] and
- Positron emission tomography (PET) scans.[25]

Researchers have found ways to test for possible indicators of Parkinson's disease. Both of these tests involve the alpha-synuclein protein; however, these tests only serve to provide information that can help a provider in making a diagnosis.[26]

- Spinal tap – Looks for misfolded alpha-synuclein proteins in cerebrospinal fluid, which is the fluid that surrounds the brain and spinal cord. This test involves a spinal tap (lumbar puncture), where a health care provider inserts a needle into the spinal canal to collect cerebrospinal fluid for testing.
- Skin biopsy – Another possible test involving a biopsy of surface nerve tissue. A biopsy includes collecting a small sample of the skin, including the nerves in the skin. The samples come from a spot on the back and two spots on the leg. Analyzing the samples can help

[20] Parkinson's Foundation, *Parkinson's Biomarkers, available at* https://www.parkinson.org/understanding-parkinsons/getting-diagnosed/biomarkers (last visited Mar. 30, 2025).
[21] *Supra* note 3.
[22] *Id*.
[23] A CT scan is a type of imaging that uses X-ray techniques to create detailed images of the body. It then uses a computer to create cross-sectional images, also called slices, of the bones, blood vessels, and soft tissues inside the body. CT scan images show more detail than plain X-rays do. *See* Mayo Clinic, *CT Scan, available at* https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675 (last visited Mar. 30, 2025).
[24] An MRI is a noninvasive medical imaging test that produces detailed images of almost every internal structure in the human body, including the organs, bones, muscles, and blood vessels. MRI scanners create images of the body using a large magnet and radio waves. No ionizing radiation is produced during an MRI exam, unlike X-rays. These images give a physician important information in diagnosing a medical condition and planning a course of treatment. *See* Johns Hopkins Medicine, *Magnetic Resonance Imaging (MRI), available at* https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/magnetic-resonance-imaging-mri#:~:text=Magnetic%20resonance%20imaging%2C%20or%20MRI,large%20magnet%20and%20radio%20waves. (last visited Mar. 30, 2025).
[25] A PET scan is an imaging test that can help reveal the metabolic or biochemical function of tissues and organs. The PET scan uses a radioactive drug called a tracer to show both typical and atypical metabolic activity. A PET scan can often detect the atypical metabolism of the tracer in diseases before the disease shows up on other imaging tests, such as a CT and an MRI. *See* Mayo Clinic, *Positron emission tomography scan, available at* https://www.mayoclinic.org/tests-procedures/pet-scan/about/pac-20385078 (last visited Mar. 30, 2025).
[26] *Supra* note 3.

determine if the alpha-synuclein protein has a certain kind of malfunction that could increase the risk of developing Parkinson's disease.

Parkinson's Disease Management and Treatment

For now, Parkinson's disease is not curable, but there are multiple ways to manage its symptoms. The treatments can also vary from person to person, depending on the specific symptoms and how well certain treatments work. Medications are the primary way to treat this condition.[27]

A secondary treatment option is surgery to implant a device that will deliver a mild electrical current to part of the brain (deep brain stimulation).[28] There are also some experimental options, such as stem cell-based treatments, however, availability often varies, and many are not an option for individuals with Parkinson's disease.[29]

Medications that do one or more of the following are used to treat Parkinson's disease:[30]

- Adding dopamine – Medications like levodopa[31] can increase the available levels of dopamine in the brain. This medication is almost always effective, and when it does not work, that is usually a sign of some other form of parkinsonism[32] rather than Parkinson's disease. Long-term use of levodopa eventually leads to side effects that make it less effective.
- Simulating dopamine – Dopamine agonists are medications that have a dopamine-like effect. Dopamine is a neurotransmitter, causing cells to act in a certain way when a dopamine molecule latches onto them. Dopamine agonists can latch on and cause cells to behave the same way. These are more common in younger patients to delay starting levodopa.
- Dopamine metabolism blockers – The body has natural processes to break down neurotransmitters like dopamine. Medications that block the body from breaking down

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[27] *Id*.

[28] In years past, surgery was an option to intentionally damage and scar a part of the brain that was malfunctioning because of Parkinson's disease. Today, that same effect is possible using deep-brain stimulation, which uses an implanted device to deliver a mild electrical current to those same areas. The major advantage is that deep-brain stimulation is reversible, while intentional scarring damage is not. This treatment approach is almost always an option in later stages of Parkinson's disease when levodopa therapy becomes less effective, and in people who have a tremor that does not seem to respond to the usual medications. *See* Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Mar. 30, 2025).

[29] Stem cell transplants add new dopamine-using neurons into the brain to take over for damaged ones. Neuron-repair treatments try to repair damaged neurons and encourage new neurons to form. Gene therapies and gene-targeted treatments target specific mutations that cause Parkinson's disease. Some also boost the effectiveness of levodopa or other treatments. *See* Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Mar. 30, 2025).

[30] *Supra* note 3.

[31] Levodopa is the precursor to dopamine. Most commonly, clinicians use levodopa as a dopamine replacement agent for the treatment of Parkinson's disease. It is most effectively used to control bradykinetic symptoms apparent in Parkinson's disease. Levodopa is typically prescribed to a patient with Parkinson's disease once symptoms become more difficult to control with other anti-parkinsonism drugs. See National Institutes of Health, National Library of Medicine, National Center for Biotechnology Information, *Levodopa (L-Dopa), available at* https://www.ncbi.nlm.nih.gov/books/NBK482140/#:~:text=Levodopa%20is%20the%20precursor%20to,symptoms%20apparent%20in%20Parkinson%20disease. (last visited Mar. 30, 2025).

[32] "Parkinsonism" is an umbrella term that describes Parkinson's disease and conditions with similar symptoms. It can refer not only to Parkinson's disease but also to other conditions like multiple system atrophy or corticobasal degeneration. *See* Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Mar. 30, 2025).

dopamine allow more dopamine to remain available to the brain. These medications are especially useful early on and can also help when combined with levodopa in later stages of Parkinson's disease.

- Levodopa metabolism inhibitors – These medications slow down how the body processes levodopa, helping it last longer. These medications may need careful use as they can have toxic effects and damage the liver. They are most often used to help as levodopa becomes less effective.
- Adenosine blockers – Medications that block how certain cells use adenosine (a molecule used in various forms throughout the body) can have a supportive effect when used alongside levodopa.
- Other medications are used to treat specific symptoms of Parkinson's disease.

Current Status of Parkinson's Disease Research in Florida

The Parkinson's Foundation designates the nation's top medical centers with specialized teams focused on Parkinson's disease clinical research and care as "Centers of Excellence."[33] Florida is home to three Parkinson's disease Centers of Excellence, including the USF's Parkinson's Disease & Movement Disorders Center,[34] the University of Florida's Movement Disorders and Neurorestoration Program,[35,36,37] and the University of Miami's Miller School of

[33] Parkinson's Foundation, *Global Care Network, available at* https://www.parkinson.org/living-with-parkinsons/finding-care/global-care-network (last visited Apr. 3, 2025).
[34] The USF's Parkinson's Disease & Movement Disorders Center is the only center in Florida primarily focused on Parkinson's disease research and treatment. The center currently offers multiple clinical trials to improve symptoms of early untreated Parkinson's disease, test innovative treatments, and study the disease's causes and progression. *See* USF Health, *Parkinson's Disease & Movement Disorders Center, available at* https://health.usf.edu/care/neurology/services-specialties/parkinsons (last visited Apr. 3, 2025).
[35] The University of Florida's (UF's) Movement Disorders and Neurorestoration Program operates within the UF's Norman Fixel Institute for Neurological Diseases and studies a variety of neurological disorders, including amyotrophic later sclerosis (ALS), dementia, Alzheimer's disease, and Parkinson's disease. See UFHealth, *About, available at* https://movementdisorders.ufhealth.org/about/ (last visited Apr. 3, 2025).
[36] Currently, the Program offers only two clinical trials for Parkinson's disease research. *See* UFHealth, *Clinical trials, available at* https://ufhealth.org/conditions-and-treatments/parkinson-disease/clinical-trials (last visited Apr. 3, 2025).
[37] The Program's Parkinson's disease research focuses on cognitive behavior and emotion, speech production, breathing and swallowing dysfunction, and development of deep brain stimulation. *See* UFHealth, *Clinical Research, available at* https://movementdisorders.ufhealth.org/research/clinical-research/ (last visited Apr. 3, 2025).

Medicine.[38,39,40,41] Comparatively, California is home to five Centers of Excellence, New York is home to four, and Texas is home to one.[42]

III. Effect of Proposed Changes:

Section 1 creates s. 1004.4352, F.S., to provide that the section may be cited as the "Parkinson's Disease Research Act."

The bill establishes the following legislative findings:
- Parkinson's disease is a progressive neurological disorder affecting approximately one million Americans, with an estimated 90,000 new diagnoses each year.
- Currently, there is no cure for Parkinson's disease, and innovative research is essential to advance therapies, improve patient outcomes, and alleviate the burden of the disease.

The bill defines the following terms:
- "Board" means the Parkinson's Disease Research Board.
- "Consortium" means the Consortium for Parkinson's Disease Research.

The bill establishes the Consortium for Parkinson's Disease Research, which consists of public and private universities, within the USF. The purpose of the consortium is to conduct rigorous scientific research and disseminate such research.

The bill establishes the Parkinson's Disease Research Board to direct the operations of the consortium. The board must be composed of members representing each participating university and appointed by the president of each participating university. Board members must have experience in a variety of scientific fields, including, but not limited to, neurology, psychology, nutrition, and genetics. Members must be appointed to four-year terms and may be reappointed to serve additional terms. The chair must be elected by the board from among its members to serve a two-year term. The board must meet at least semi-annually at the call of the chair or, in his or her absence or incapacity, the vice chair. Four members constitute a quorum. A majority

[38] The University of Miami's Miller School of Medicine does not have a program specifically designated for researching Parkinson's disease. However, the Miller School of Medicine's John P. Hussman Institute for Human Genomics researches Parkinson's disease's genetic causes, along with other genetic disorders such as Autism and Alzheimer's disease. *See* Miller School of Medicine, *Parkinson Disease, available at* https://med.miami.edu/centers-and-institutes/hihg/research-programs/parkinson-disease (last visited Apr. 3, 2025).
[39] The Institute does not study Parkinson's disease beyond its genetic causes. The Miller School of Medicine also partners with the American Parkinson Disease Association's (APDA) to host the APDA's Information and Referral Center. *See* Miller School of Medicine, *New Center Expands Services to Parkinson's Disease Community, Targeting Underserved Spanish-Speaking Population, available at* https://news.med.miami.edu/new-center-expands-services-to-parkinsons-disease-community-targeting-underserved-spanish-speaking-population/#:~:text=The%20Miller%20School%20is%20a%20Parkinson%E2%80%99s%20Foundation%20Center,treatments%20and%20research%20while%20providing%20the%20best%20care (last visited Apr. 3, 2025).
[40] The Center operates a telephone helpline, provides resources on symptoms and therapies, and connects patients with physicians and specialists. *See* American Parkinson Disease Association, *APDA's Grassroots Network: APDA Information & Referral Centers, available at* https://www.apdaparkinson.org/article/our-network-of-information-and-referral-centers/ (last visited Apr. 3, 2025).
[41] Parkinson's Foundation, *Florida Chapter, available at* https://www.parkinson.org/florida/florida-chapter#florida-chapter (last visited Apr. 3, 2025).
[42] *Supra* note 33.

vote of the members present is required for all actions of the board. The board may prescribe, amend, and repeal a charter governing the manner in which it conducts its business. Board members must serve without compensation, but are entitled to receive reimbursement for travel expenses by the consortium or the organization he or she represents in accordance with s. 112.061, F.S.

The bill requires the consortium to be administered by a director, who must be appointed by and serve at the pleasure of the board. The director must, subject to the approval of the board:

- Propose a budget for the consortium.
- Foster the collaboration of scientists, researchers, and other appropriate personnel in accordance with the consortium's charter.
- Engage individuals in public and private university programs relevant to the consortium's work to participate in the consortium.
- Identify and prioritize the research to be conducted by the consortium.
- Prepare a plan for Parkinson's disease research for submission to the board.
- Apply for grants to obtain funding for research conducted by the consortium.
- Perform other duties as determined by the board.

The bill requires the board to annually adopt a plan for Parkinson's disease research. The plan must organize a program of research that contributes to the body of scientific knowledge on the causes, mechanisms, and potential treatments for Parkinson's disease and the prevalence of Parkinson's disease in first responders. The board must award funds to members of the consortium to perform research consistent with the plan.

The bill requires that the board issue a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on research projects, research findings, community outreach initiatives, and future plans for the consortium by October 15 of each year.

Section 2 creates a non-statutory section of the Laws of Florida to require the following allocation of funds, subject to appropriations from the General Appropriations Act:

- 67 percent of funds appropriated are directed to the USF for Parkinson's disease research including, but not limited to, identifying the genetic origin of the disease and developing therapeutic interventions to slow or stop the progression of the disease.
- 33 percent of funds appropriated are directed to the USF for the Consortium for Parkinson's Disease Research.

Section 3 provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

As written, the bill has no fiscal impact on state expenditures; however, its function is dependent on the appropriation of funds from the General Appropriations Act.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not speak to how the public or private universities are chosen to participate in the consortium. The bill is also silent as to the term of service for the director of the consortium.

VIII. Statutes Affected:

This bill creates section 1004.4352 of the Florida Statutes.

The bill creates undesignated sections of the Laws of Florida.

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:
The committee substitute:

- Deletes the underlying bill's Parkinson's Disease Research Program established within the Florida Department of Health.
- Creates the Parkinson's Disease Research Act within the Education Code instead of public health statutes.
- Establishes a Consortium for Parkinson's Disease Research within the USF and establishes a Parkinson's Disease Research Board to direct the operations of the consortium.
- Requires the board to annually adopt a plan for Parkinson's disease research and to submit a report to the Governor and the Legislature.
- Removes the underlying bill's appropriation of funds and provides that, subject to appropriations, specific percentages of funds be used for certain purposes.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
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	.	

The Committee on Health Policy (Calatayud) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 1004.4352, Florida Statutes, is created to read:

1004.4352 Parkinson's disease research.—

(1) SHORT TITLE.—This section may be cited as the "Parkinson's Disease Research Act."

(2) LEGISLATIVE FINDINGS.—The Legislature finds that:

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(a) Parkinson's disease is a progressive neurological disorder affecting approximately one million Americans, with an estimated 90,000 new diagnoses each year.

(b) Currently, there is no cure for Parkinson's disease, and innovative research is essential to advance therapies, improve patient outcomes, and alleviate the burden of the disease.

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

(a) "Board" means the Parkinson's Disease Research Board.

(b) "Consortium" means the Consortium for Parkinson's Disease Research.

(4) CONSORTIUM FOR PARKINSON'S DISEASE RESEARCH.—

(a) There is established within the University of South Florida the Consortium for Parkinson's Disease Research which shall consist of public and private universities. The purpose of the consortium is to conduct rigorous scientific research and disseminate such research.

(b) The Parkinson's Disease Research Board is established to direct the operations of the consortium. The board shall be composed of members representing each participating university and appointed by the president of each participating university. Board members must have experience in a variety of scientific fields, including, but not limited to, neurology, psychology, nutrition, and genetics. Members shall be appointed to 4-year terms and may be reappointed to serve additional terms. The chair shall be elected by the board from among its members to serve a 2-year term. The board shall meet at least semiannually at the call of the chair or, in his or her absence or incapacity, the vice chair. Four members constitute a quorum. A

614080

majority vote of the members present is required for all actions of the board. The board may prescribe, amend, and repeal a charter governing the manner in which it conducts its business. Board members shall serve without compensation, but are entitled to receive reimbursement for travel expenses by the consortium or the organization he or she represents in accordance with s. 112.061.

(c) The consortium shall be administered by a director, who shall be appointed by and serve at the pleasure of the board. The director shall, subject to the approval of the board:

1. Propose a budget for the consortium.

2. Foster the collaboration of scientists, researchers, and other appropriate personnel in accordance with the consortium's charter.

3. Engage individuals in public and private university programs relevant to the consortium's work to participate in the consortium.

4. Identify and prioritize the research to be conducted by the consortium.

5. Prepare a plan for Parkinson's disease research for submission to the board.

6. Apply for grants to obtain funding for research conducted by the consortium.

7. Perform other duties as determined by the board.

(d) The board shall annually adopt a plan for Parkinson's disease research. The plan must organize a program of research that contributes to the body of scientific knowledge on the causes, mechanisms, and potential treatments for Parkinson's disease and the prevalence of Parkinson's disease in first

614080

responders. The board must award funds to members of the consortium to perform research consistent with the plan.

(e) By October 15 of each year, the board shall issue a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on research projects, research findings, community outreach initiatives, and future plans for the consortium.

Section 2. (1) Subject to appropriations from the General Appropriations Act, 67 percent of funds appropriated are directed to the University of South Florida for Parkinson's disease research including, but not limited to, identifying the genetic origin of the disease and developing therapeutic interventions to slow or stop the progression of the disease.

(2) Subject to appropriations from the General Appropriations Act, 33 percent of funds appropriated are directed to the University of South Florida for the Consortium for Parkinson's Disease Research.

Section 3. This act shall take effect July 1, 2025.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to Parkinson's disease; creating s. 1004.4352, F.S.; providing a short title; providing legislative findings; defining terms; establishing the Consortium for Parkinson's Disease Research within the University of South Florida; establishing the

614080

Parkinson's Disease Research Board; providing for the membership of the board; requiring the board to direct the operations of the consortium and to annually adopt a plan for Parkinson's disease research; providing duties of the consortium director; providing research requirements for the plan; requiring the board to award funds to board members for certain purposes; requiring the board to issue an annual report to the Governor and Legislature by a specified date; providing appropriations; providing an effective date.

By Senator Calatayud

38-01506A-25 20251800__

A bill to be entitled

An act relating to Parkinson's disease research funding; creating s. 381.992, F.S.; providing a short title; establishing the Parkinson's Disease Research Program; providing the purpose of the program; requiring the Department of Health to create a specified registry; providing for coverage of specified testing; providing for funding and allocations; requiring the Department of Health to establish the Parkinson's Disease Research Advisory Board; providing requirements for board membership and duties; providing for future legislative review and repeal of the advisory board; requiring grant recipients to annually submit a specified report to the department; providing an effective date.

WHEREAS, Parkinson's disease is a progressive neurological disorder affecting approximately one million Americans, with an estimated 90,000 new diagnoses each year, and

WHEREAS, there is currently no cure for Parkinson's disease, and innovative research is essential to advance therapies, improve patient outcomes, and alleviate the burden of this disease, NOW, THEREFORE,

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

Section 1. Section 381.992, Florida Statutes, is created to read:

381.992 Parkinson's disease research.—

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(1) SHORT TITLE.—This section may be cited as the "Parkinson's Disease Research Fund Act."

(2) PROGRAM ESTABLISHMENT AND REGISTRY.—

(a) The Parkinson's Disease Research Program is established within the Department of Health.

(b) The program shall support innovative research and provide caregiver assistance as described in this section.

(c) The Department of Health shall create a Parkinson's Disease Research Program Registry of individuals served by the program.

(3) AVAILABILITY OF COVERAGE.—A health plan as defined in s. 408.7057(1) shall cover the costs of Parkinson's disease biomarker testing for individuals under this program.

(4) FUNDING AND ALLOCATION.—

(a) The Legislature shall appropriate funds from the General Revenue Fund to the program for fiscal year 2025-2026.

(b) The funds shall be allocated through grants as follows:

1. Twenty million dollars shall be awarded through competitive grants to state universities, research institutions, and medical centers actively engaged in Parkinson's disease research with priority given to innovative therapies and projects aimed at finding a cure.

2. Five million dollars shall be used to establish and expand programs that support caregivers of individuals living with Parkinson's disease, including respite care, training, and mental health resources.

(5) ADMINISTRATION AND OVERSIGHT.—The Department of Health shall establish the Parkinson's Disease Research Advisory Board, an advisory body, as defined in s. 20.03, to oversee the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

administration of the program.

(a) The advisory board shall consist of representatives from:

1. Leading research institutions in the state.

2. Parkinson's disease advocacy organizations.

3. Caregiver support groups.

4. The medical community specializing in neurological diseases.

(b) The advisory board shall establish guidelines for grant applications, selection criteria, and reporting requirements to ensure transparency and accountability.

(c) In accordance with s. 20.052(8), this subsection is repealed October 2, 2028, unless reviewed and saved from repeal through reenactment by the Legislature.

(6) REPORTING.—Recipients of grant funds shall submit an annual report to the Department of Health detailing all of the following:

(a) The progress of funded research.

(b) Outcomes and measurable impacts of caregiver support programs.

(c) Any additional recommendations for improving the effectiveness of the program.

Section 2. This act shall take effect October 1, 2025.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 10, 2025

I respectfully request that **Senate Bill #1800**, relating to Parkinson's Disease Research Funding, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Alexis Calatayud

Senator Alexis Calatayud
Florida Senate, District 38

File signed original with committee office

S-020 (03/2004)

Tab 14

The Florida Senate
APPEARANCE RECORD

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

APRIL 1, 2025
Meeting Date

HEALTH POLICY
Committee

SB 1800
Bill Number or Topic

#614080 DELETE ALL
Amendment Barcode (if applicable)

Name MARK WALSH

Phone 813 974 1830

Address 4202 E. FOWLER AVE, CGS401
Street

Email mwalsh@usf.edu

TAMPA FL 33620
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
UNIVERSITY OF SOUTH FLORIDA (USF)

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

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

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

S-001 (08/10/2021)

Tab 14

The Florida Senate

APPEARANCE RECORD

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

April 1, 2025
Meeting Date

Health Policy
Committee

SB 1800
Bill Number or Topic

Amendment Barcode (if applicable)

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Michael J. Fox Foundation for Parkinson's Research

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

4-1-2025
Meeting Date

SB 1800
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

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PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Mayo Clinic

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 596
INTRODUCER:	Senator Leek
SUBJECT:	Cardiac Services Providers
DATE:	March 31, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 596 amends s. 395.1055, F.S., to require the Agency for Health Care Administration (AHCA) to grant licensure for Level I or Level II adult cardiovascular services (ACS) programs to a hospital that meets specified criteria, rather than requiring the AHCA to adopt such criteria in rule.

Specific to Level I programs, the bill eliminates the requirement that a hospital demonstrate a specified volume of patients needing ACS prior to licensure and the requirement that nursing and technical staff have demonstrated experience in providing ACS.

For both Level I and Level II programs, the bill requires that such programs comply with guidelines from the Society for Cardiovascular Angiography and Interventions and, if the hospital provides electrophysiology services, the Heart Rhythm Society, in addition to the current-law requirement that hospitals comply with guidelines from the American College of Cardiology and the American Heart Association.

Additionally, the bill requires the AHCA to update its rules to administer the requirements of part II, of ch. 408, F.S., as new industry standards and guidelines are published.

The bill provides an effective date of October 1, 2025.

II. Present Situation:

Adult Cardiovascular Services

ACS include one or more of the following services provided at a hospital that is licensed to provide such service.

Adult Diagnostic Cardiac Catheterization

Adult Diagnostic Cardiac Catheterization (DDC) is a test or treatment for certain heart or blood vessel problems, such as clogged arteries or irregular heartbeats. The procedure uses a thin, hollow tube called a catheter. The tube is guided through a blood vessel to the heart. DDC gives important details about the heart muscle, heart valves, and blood vessels in the heart. During the procedure, a doctor can test the pressures in the heart or do treatments such as opening a narrowed artery. Sometimes a piece of heart tissue is removed for examination. Usually, a patient is awake during cardiac catheterization but given medicines to help with relaxation. The risk of major complications is generally low.[1]

The AHCA licenses hospitals to provide DDC under requirements established in subsection (1) of Rule 59A-3.246, F.A.C. Currently, there are 22 hospitals in Florida licensed to provide adult DDC.[2]

Level I Adult Cardiovascular Services

Section 395.1055, F.S., specifies that a license to provide Level I ACS authorizes the licensed hospital to provide adult percutaneous cardiac intervention (PCI) without onsite cardiac surgery. PCI is a minimally invasive procedure to open blocked coronary arteries. An older name for PCI is coronary angioplasty with stenting, or angioplasty for short. Arteries are the blood vessels that carry oxygen-rich blood from the heart throughout the body. A PCI procedure uses a small balloon to reopen a blocked artery to increase blood flow. Usually, the cardiologist places a small, permanent tube (stent) to keep the artery open long-term. The stent usually contains medication that releases directly into the artery (drug-eluting stent) to reduce the risk of re-narrowing within the stent.[3]

In order to be licensed to provide Level I ACS, a hospital must meet the requirements established by the AHCA in Rule 59A-3.246(2), F.A.C. For initial licensure, these requirements include, but are not limited to, that the hospital must have provided a minimum of 300 adult inpatient and outpatient DDC or, for the most recent 12-month period, has discharged or transferred a minimum of 300 patients with the principal diagnosis of ischemic heart disease and the intent and ability to comply with the 2012 ACC/SCAI Guidelines and the 2014 Update on Percutaneous Coronary Intervention Without Onsite Surgical Backup.[4, 5] Additionally, a hospital

[1] Mayo Clinic, *Cardiac Catheterization*, available at https://www.mayoclinic.org/tests-procedures/cardiac-catheterization/about/pac-20384695 (last visited March 27, 2025).
[2] Florida Health Finder search, *available at* https://quality.healthfinder.fl.gov/Facility-Provider/Hospital?&type=1 (last visited Mar. 27, 2025).
[3] Cleveland Clinic, *Percutaneous Coronary Intervention*, 11/06/21, *available at* https://my.clevelandclinic.org/health/treatments/22066-percutaneous-coronary-intervention (last visited Mar. 27, 2025).
[4] Bashore, T, Balter, S, Barac, A. et al. 2012 American College of Cardiology Foundation/Society for Cardiovascular Angiography and Interventions Expert Consensus Document on Cardiac Catheterization Laboratory Standards Update: A Report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents. JACC. 2012 Jun, 59 (24) 2221–2305, *available at* https://www.sciencedirect.com/science/article/pii/S0735109712005104 (last visited Mar. 27, 2025).
[5] Gregory J. Dehmer, MD, James C. Blankenship, MD, Mehmet Cilingiroglu, MD, James G. Dwyer, MD, Dmitriy N. Feldman, MD, Timothy J. Gardner, MD, Cindy L. Grines, MD, and Mandeep Singh, MD, MPH, SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup. AHA/ASA Journals, Volume 129, Number 24. March 17, 2014, *available at* https://www.ahajournals.org/doi/10.1161/CIR.0000000000000037 (last visited Mar. 27, 2025).

licensed to provide Level I ACS must have a transfer agreement with a hospital licensed as a Level II ACS provider.

Staff at a Level I ACS provider must meet the following criteria:

- At initial licensure, each cardiologist must be an experienced physician who has performed a minimum of 50 interventional cardiology procedures, including at least 11 primary cardiology interventional procedures, exclusive of fellowship training, and within the previous 12 months from the date of the Level I adult cardiovascular licensure application.
- At licensure renewal, interventional cardiologists must perform a minimum of 50 interventional cardiology procedures per year averaged over a two-year period or be confirmed by the review process described in subparagraph 59A-3.246(3)(b)3., F.A.C.
- Technical catheterization laboratory staff must be credentialed as Registered Cardiovascular Invasive Specialist or must complete a hospital-based education and training program at a hospital providing Level I or Level II adult cardiovascular services. This training program must include a minimum of 500 hours proctored clinical experience, including participation in a minimum of 120 interventional cardiology procedures and didactic education components of hemodynamics, pharmacology, arrhythmia recognition, radiation safety, and interventional equipment.
- Coronary care unit nursing staff must be trained and experienced with invasive hemodynamic monitoring, operation of temporary pacemaker, management of Intra-Aortic Balloon Pump, management of in-dwelling arterial/venous sheaths and identifying potential complications such as abrupt closure, recurrent ischemia and access site complications.

Currently, there are 68 hospitals in Florida licensed to provide Level I ACS.[6]

Level II Adult Cardiovascular Services

A Level II ACS license authorizes a hospital to provide the performance of PCI with onsite cardiac surgery.[7] In addition to the above requirements, a Level II ACS provider must demonstrate at initial licensure that for the most recent 12-month period, the hospital has provided a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic cardiac catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease and each cardiac surgeon is required to be board certified.

Currently, there are 78 Florida hospitals licensed to provide Level II ACS.[8]

III. Effect of Proposed Changes:

SB 596 amends s. 395.1055, F.S., to require the AHCA to grant licensure to provide Level I or Level II ACS if a hospital meets the requirements established in statute, rather than requiring the AHCA to adopt rules for such licensure that include the minimum requirements provided in statute.

[6] *Supra* n. 2
[7] Section 395.1055(18)(a), F.S.
[8] *Supra* n. 2

Specific to Level I ACS licensure, the bill *eliminates* the requirements that:

- A hospital must demonstrate that the hospital must have provided a minimum of 300 adult inpatient and outpatient DDC or, for the most recent 12-month period, has discharged or transferred a minimum of 300 patients with the principal diagnosis of ischemic heart disease and a related exception for hospitals located more than 100 road miles from a Level II ACS provider; and
- At a minimum, nursing and technical staff have demonstrated experience in handling acutely ill patients requiring intervention, based on the staff member's previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open heart surgery program, the staff member's previous experience qualifies only if, at the time the staff member acquired his or her experience, the dedicated cardiac interventional laboratory:
  - Had an annual volume of 500 or more percutaneous cardiac intervention procedures.
  - Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures.
  - Experienced a complication rate of less than five percent for percutaneous cardiac intervention procedures.
  - Performed diverse cardiac procedures, including, but not limited to, balloon angioplasty and stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.

For both Level I and Level II programs, the bill requires that such programs comply with guidelines from the Society for Cardiovascular Angiography and Interventions and, if the hospital provides electrophysiology services, the Heart Rhythm Society, in addition to the current-law requirement that hospitals comply with guidelines from the American College of Cardiology and the American Heart Association.

Additionally, the bill requires the AHCA to update its rules to administer the requirements of part II, of ch. 408, F.S., as new industry standards and guidelines are published.

The bill provides an effective date of October 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Article III Section 6 of the Florida Constitution requires that "every law shall embrace but one subject and matter properly connected therewith, and the subject shall be briefly expressed in the title." The title of SB 596 is "an act relating to cardiac services providers." However, lines 114-117 of the bill amend the AHCA's grant of rulemaking authority to administer the requirements of part II, of ch. 408, F.S., which apply to *all* facilities that the AHCA regulates, and not just to cardiac services providers. As such, it is possible that lines 114-117 may be unconstitutional as the changes on those lines may exceed the scope of the bill provided in the bill's title.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

SB 596 amends s. 395.1055(18), F.S., to require the AHCA to grant licensure to provide Level I or Level II ACS if a hospital meets the requirements established in statute, rather than requiring the AHCA to adopt rules for such licensure that include the minimum requirements provided in statute.

However, subsection (17) of that statute, which is not amended by the bill, provides that "each provider of adult cardiovascular services or operator of a burn unit shall comply with *rules adopted by the agency which establish licensure standards that govern the provision of adult cardiovascular services* or the operation of a burn unit, as applicable. At a minimum, such rules must address staffing, equipment, physical plant, operating protocols, the provision of services to Medicaid and charity care patients, accreditation, licensure periods and fees, and enforcement of minimum standards."

As such, it is unclear whether the AHCA would be required to license an ACS provider that meets the minimum requirements provided in subsection (18) even if the provider is unable to meet the minimum standards established by the AHCA pursuant to subsection (17).

VIII. Statutes Affected:

This bill substantially amends section 395.1055 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Leek

7-00346A-25 2025596__

A bill to be entitled

An act relating to cardiac services providers; amending s. 395.1055, F.S.; revising requirements for licensure of Level I and Level II adult cardiovascular programs; requiring the Agency for Health Care Administration to update specified rules as new applicable industry standards and guidelines are published; providing an effective date.

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

Section 1. Subsections (18) and (19) of section 395.1055, Florida Statutes, are amended to read:

395.1055 Rules and enforcement.—

(18)(a) ~~In establishing rules for adult cardiovascular services,~~ The agency shall grant licensure ~~include provisions that allow~~ for~~:~~

~~(a)~~ the establishment of two hospital program licensure levels, a Level I program that authorizes the performance of adult percutaneous cardiac intervention without onsite cardiac surgery, including rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions, and a Level II program that authorizes the performance of percutaneous cardiac intervention with onsite cardiac surgery.

(b)~~1.~~ ~~For~~ A hospital seeking licensure as a Level I program must:~~, demonstration that, for the most recent 12-month period as reported to the agency, the hospital has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

~~discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease and that it has~~

1. Have a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes.

2.~~a. A hospital located more than 100 road miles from the closest Level II adult cardiovascular services program is not required to meet the diagnostic cardiac catheterization volume and ischemic heart disease diagnosis volume requirements in subparagraph 1. if the hospital demonstrates that it has, for the most recent 12-month period as reported to the agency, provided a minimum of 100 adult inpatient and outpatient diagnostic cardiac catheterizations or that, for the most recent 12-month period, it has discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease.~~

~~b.~~ For a hospital located more than 100 road miles from the closest Level II adult cardiovascular services program, have ~~does not need to meet the 60-minute transfer time protocol requirement in subparagraph 1. if the hospital demonstrates that it has~~ a formalized, written transfer agreement with a hospital that has a Level II program. The agreement must include written transport protocols to ensure the safe and efficient transfer of a patient, taking into consideration the patient's clinical and physical characteristics, road and weather conditions, and viability of ground and air ambulance service to transfer the patient.

~~3. At a minimum, the rules for adult cardiovascular services must require nursing and technical staff to have~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

~~demonstrated experience in handling acutely ill patients requiring intervention, based on the staff member's previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open heart surgery program, the staff member's previous experience qualifies only if, at the time the staff member acquired his or her experience, the dedicated cardiac interventional laboratory:~~

~~a. Had an annual volume of 500 or more percutaneous cardiac intervention procedures.~~

~~b. Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures.~~

~~c. Experienced a complication rate of less than 5 percent for percutaneous cardiac intervention procedures.~~

~~d. Performed diverse cardiac procedures, including, but not limited to, balloon angioplasty and stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.~~

(c) ~~For~~ A hospital seeking licensure as a Level II program must demonstrate~~, demonstration~~ that, for the most recent 12-month period as reported to the agency, the hospital has performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

(d) As a condition of licensure as a Level I or Level II program, a hospital must demonstrate all of the following:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1. Compliance with the most recent guidelines of the American College of Cardiology, ~~and~~ the American Heart Association, the Society for Cardiovascular Angiography and Interventions, and, for hospitals providing electrophysiology services, the Heart Rhythm Society ~~guidelines~~ for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria, to ensure patient quality and safety.

2.~~(e)~~ The establishment of appropriate hours of operation and protocols to ensure availability and timely referral in the event of emergencies.

3.~~(f) The demonstration of~~ A plan to provide services to Medicaid and charity care patients.

4.~~(g)~~ For a hospital licensed as a ~~for adult diagnostic cardiac catheterization that provides~~ Level I or Level II program for adult cardiovascular services, ~~demonstration~~ that the hospital is participating in the American College of Cardiology's National Cardiovascular Data Registry or the American Heart Association's Get with the Guidelines-Coronary Artery Disease registry and documentation of an ongoing quality improvement plan ensuring that the licensed cardiac program meets or exceeds national quality and outcome benchmarks reported by the registry in which the hospital participates. A hospital licensed for Level II adult cardiovascular services must also participate in the clinical outcome reporting systems operated by the Society for Thoracic Surgeons.

(19) The agency may adopt rules to administer the requirements of part II of chapter 408 and shall update such rules as new applicable industry standards and guidelines are

published.

Section 2. This act shall take effect October 1, 2025.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 21, 2025

I respectfully request that **Senate Bill #596**, relating to Cardiac Services Provider, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Sincerely,

Sen. Tom Leek
Florida Senator, District 7

File signed original with committee office

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1768
INTRODUCER:	Health Policy Committee and Senator Trumbull
SUBJECT:	Stem Cell Therapy
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.			AHS	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1768 authorizes physicians (medical doctors and doctors of osteopathic medicine) to perform stem cell therapies that have not been approved by the U.S. Food and Drug Administration (FDA) when used for orthopedic conditions, wound care, or pain management. The bill establishes standards for the manufacturing and storage of stem cells and requires a physician to obtain a signed informed consent form from a patient before administering any such therapy.

The bill also requires that written notice be provided to a patient prior to the performance of stem cell therapy, disclosing that the therapy is not approved by the FDA. This disclosure must also be included in any advertisement for the therapy. The bill directs the Board of Medicine and Board of Osteopathic Medicine to adopt rules to implement the bill.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Overview of Stem Cells and Stem Cell Therapy

Stem cells are undifferentiated cells with the unique ability to develop into specialized cell types and to divide indefinitely under certain conditions.[1] They are broadly classified as either embryonic or adult (somatic) stem cells. Embryonic stem cells, derived from early-stage embryos, are pluripotent and capable of differentiating into nearly all cell types in the human body. Adult stem cells are more limited in scope and typically generate only cell types consistent with their tissue of origin.

In 2007, researchers developed induced pluripotent stem cells (iPSCs), a type of adult stem cell reprogrammed to exhibit pluripotency.[2] These iPSCs have opened new frontiers in regenerative medicine by offering a potential alternative to the use of embryonic stem cells.

Stem cell therapy involves administering stem cells or derivatives to repair, replace, or regenerate human tissues. While hematopoietic stem cell transplants for blood disorders are established treatments, many other stem cell therapies remain experimental and are not approved by the FDA for routine clinical use.[3]

Federal Regulation of Human Cells, Tissues, and Cellular and Tissue-Based Products

The FDA regulates stem cell products that meet the definition of human cells, tissues, or cellular and tissue-based products (HCT/Ps) through its Center for Biologics Evaluation and Research (CBER).[4] CBER's authority derives from the Public Health Service Act (42 U.S.C. § 264) and the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 301 et seq.). Applicable federal regulations are found primarily in 21 C.F.R., part 1271.

Products that meet all of the criteria under 21 C.F.R. § 1271.10 – commonly referred to as "361 HCT/Ps" – are subject to less stringent oversight. To qualify, the product must be:

- Minimally manipulated;
- Intended solely for homologous use;
- Not combined with another article (except for certain preservatives or water); and
- Either non-systemic and not dependent on the metabolic activity of living cells for its primary function, or used autologously or in a first- or second-degree blood relative.

Products that do not meet these criteria are classified as "351 HCT/Ps" and are regulated as biological drugs. These products require premarket approval through the FDA's Investigational

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[1] Department of Health, Senate Bill 1617 *Legislative Analysis* (Mar. 19, 2025) (on file with the Senate Committee on Health Policy). Note that House Bill 1617 would be substantively identical to Senate Bill 1768 except for the House bill's exclusion of legislative intent and the inclusion of the use of afterbirth placental perinatal stem cells in the definition of "stem cell therapy."

[2] *Id.*

[3] Harvard Stem Cell Institute, *Frequently Asked Questions: Stem Cell Therapies*, *available at*: https://www.hsci.harvard.edu/faq/stem-cell-therapies (last visited Mar. 28, 2025).

[4] U.S. Food & Drug Administration, *Center for Biologics Evaluation and Research (CBER)*, *available at*: https://www.fda.gov/about-fda/fda-organization/center-biologics-evaluation-and-research-cber (last visited Mar. 28, 2025).

New Drug (IND) and Biologics License Application (BLA) pathways, under 21 C.F.R., parts 312 and 600–680.

Enforcement and Oversight by FDA

The FDA requires establishments that manufacture or manipulate HCT/Ps to register with CBER and to comply with current Good Tissue Practices (cGTPs) under 21 C.F.R. part 1271, subpart D.[5] These practices are designed to prevent the introduction or transmission of communicable diseases. The FDA conducts inspections, issues warning letters, and may pursue civil or criminal enforcement actions against facilities or providers offering unapproved or noncompliant stem cell therapies.

The FDA has issued warnings about the widespread marketing of unapproved regenerative medicine products, noting that approval is granted only after rigorous evaluation in clinical trials to ensure safety and efficacy.[6] The FDA has received reports of serious adverse events associated with unapproved regenerative medicine therapies, including blindness, tumor formation, and infections.[7] Consumers are advised to exercise caution and are encouraged to report any adverse effects or file complaints related to these products directly to the FDA.

Oversight by the Florida Boards of Medicine and Osteopathic Medicine[8]

The Florida Board of Medicine (BOM), under the DOH, is responsible for licensing, regulating, and disciplining medical doctors, a.k.a. allopathic physicians, pursuant to ch. 458, F.S. The Board of Osteopathic Medicine (BOOM), pursuant to ch. 459, F.S., exercises the same authority for osteopathic physicians. The BOM has the authority to impose disciplinary sanctions, including license suspension or revocation, for violations of the standard of care, deceptive advertising, or failure to obtain proper informed consent, under s. 456.072, F.S., and related provisions of the Medical Practice Act. The BOOM has the authority to impose similar disciplinary sanctions under s. 459.015, F.S., which governs grounds for disciplinary action against osteopathic physicians.

In recent years, the BOM has reviewed complaints against physicians advertising unproven stem cell treatments for conditions such as orthopedic pain and neurodegenerative disorders. Some of these physicians have been subject to formal investigations, fines, and, in certain cases, license restrictions or revocations. In 2013, the BOM revoked the licenses of two physicians in administrative cases involving stem cells for failing to meet the standard of care. In 2015, the BOM warned physicians and consumers that they should be aware of the risks involved accessing stem cell therapies and regenerative medicine that was not approved by the FDA. The BOM further warned that a physician providing stem cell treatment should do so only with an

[5] *See also* U.S. Department of Health & Human Services, *Current Good Tissue Practice (CGTP) and Additional Requirements for Manufacturers of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps)*, *available a*t: https://www.hhs.gov/guidance/document/current-good-tissue-practice-cgtp-and-additional-requirements-manufacturers-human-cells (last visited Mar. 28, 2025).
[6] U.S. Food & Drug Administration, *Important Patient and Consumer Information About Regenerative Medicine Therapies*, *available at*: https://www.fda.gov/vaccines-blood-biologics/consumers-biologics/important-patient-and-consumer-information-about-regenerative-medicine-therapies (last visited Mar. 28, 2025).
[7] *Id.*
[8] *Supra* note 1.

investigational new drug application (IND) or a single patient IND for Compassionate or Emergency Use.

Ethical Considerations and Prohibited Stem Cell Sources

Federal law does not explicitly prohibit the use of fetal-derived stem cells obtained from elective abortions; however, such use is subject to ethical oversight, particularly in federally funded research. The National Institutes of Health requires review by an ethics advisory board for proposed research involving fetal tissue.[9]

III. Effect of Proposed Changes:

Sections 1 and 2 of the bill create ss. 458.3245 and 459.0127, F.S., to authorize allopathic and osteopathic physicians, respectively, to perform stem cell therapies that are not approved by the FDA and to impose requirements relating to the manufacture, use, notice, consent, and oversight of such therapies.

Subsection (1) of each section provides legislative findings and intent, recognizing the potential of stem cell therapies to advance medical treatment and improve patient outcomes. This portion of the bill emphasizes the importance of using ethically sourced stem cells and expresses the intent to prohibit the use of stem cells derived from aborted fetuses. Instead, the bill encourages the use of adult stem cells, umbilical cord blood, and other ethically obtained human cells, tissues, or cellular or tissue-based products.

Subsection (2) of each section defines key terms used throughout the section:

- "Human cells, tissues, or cellular or tissue-based products" includes specified articles consisting of human cells or tissues collected from cord blood donors who are residents of the United States and intended for implantation, transplantation, infusion, or transfer into a human recipient. The subsection also lists exclusions from that definition, including vascularized human organs, whole blood and blood derivatives, secreted or extracted products (except semen, which is a human cell, tissue, or cellular-based tissue product under the bill), certain minimally manipulated bone marrow products, ancillary products used in manufacturing, non-human-derived tissues, in vitro diagnostic products, blood vessels recovered with organs for transplantation, fetal-derived stem cells, and adipose-derived mesenchymal stem cells for transplantation.
- "Minimally manipulated" is defined in two parts: for structural tissue, it means processing that does not alter the original relevant characteristics of the tissue relating to reconstruction, repair, or replacement; for cells or nonstructural tissues, it means processing that does not alter the relevant biological characteristics of the cells or tissues.
- "Physician" is defined as a physician licensed under ch. 458, F.S., or an osteopathic physician licensed under ch. 459, F.S., acting within the scope of his or her employment.
- "Stem cell therapy" is defined as a treatment involving human cells, tissues, or cellular or tissue-based products, and explicitly excludes any treatment or research using cells or tissues derived from a fetus or embryo following an abortion.

[9] National Institutes of Health, *Policies and Procedures for the Use of Human Fetal Tissue (HFT) in Non-Transplantation Research, available at*: https://oir.nih.gov/sourcebook/ethical-conduct/special-research-considerations/policies-procedures-use-human-fetal-tissue-hft-non-transplantation-research (last visited Mar. 28, 2025).

Subsection (3) of each section authorizes physicians to perform stem cell therapy not approved by the FDA, if the therapy is used for treatment or procedures within the scope of the physician's practice and is limited to the fields of orthopedics, wound care, or pain management.

Subsection (3) of each section also establishes requirements relating to the origin and preparation of the stem cells used. The stem cells must be manufactured in a clean room certified by the FDA for the use of high-efficiency particulate air (HEPA) filtration or ultra-low penetration air filtration to minimize contamination. Additionally, the facility where the stem cells are retrieved, manufactured, and stored must be registered and regulated by the FDA and licensed or registered with one of four specified organizations: the National Marrow Donor Program, the World Marrow Donor Association, the Association for the Advancement of Blood and Biotherapies, or the American Association of Tissue Banks.

Subsection (4) of each section requires physicians to comply with applicable current good manufacturing practices for the collection, removal, processing, implantation, and transfer of stem cells or stem cell-containing products. These practices must be consistent with the requirements of the Federal Food, Drug, and Cosmetic Act and relevant regulations under 21 C.F.R., part 1271.

Subsection (5) of each section requires a physician to deliver a specific written notice to the patient before performing a stem cell therapy. The notice must state that the physician performs one or more stem cell therapies that have not yet been approved by the FDA and must advise the patient to consult with their primary care provider before undergoing any such therapy.

Subsection (6) of each section specifies the formatting and delivery requirements for the written notice. The notice must be printed on paper at least 8.5 inches by 11 inches in size and in no less than 40-point type. It must be prominently displayed at the entrance to the physician's office and in an area visible to patients within the office. In addition, the notice must be included in all advertisements for the stem cell therapy and must appear in a font size no smaller than the largest font size used in the advertisement.

Subsection (7) of each section requires that physicians obtain a signed consent form from the patient or, if the patient is not legally competent, from the patient's representative, before performing the therapy. The form must include, in language understandable to the patient or representative, a description of the nature and character of the treatment, a statement about the treatment's FDA approval status, the anticipated results, alternative treatment options, and the recognized serious possible risks, complications, and benefits of the proposed treatment and of any alternatives, including the possible consequences of not undergoing treatment.

Subsection (8) of each section identifies two categories of physicians to whom the requirements of the section do not apply. The first exemption applies to a physician who has obtained FDA approval for an investigational new drug or device for the use of human cells, tissues, or cellular or tissue-based products. The second exemption applies to a physician who performs stem cell therapy under an employment or other contract on behalf of an institution that is certified by one of the following organizations: the Foundation for the Accreditation of Cellular Therapy; the Blood and Marrow Transplant Clinical Trials Network; the Association for the Advancement of

Blood and Biotherapies; or another entity with expertise in stem cell therapy as determined by the DOH.

Subsection (9) of each section provides that a violation of any provision in the section may subject the physician to disciplinary action. The appropriate regulatory board or the DOH may enforce compliance and impose sanctions.

Subsection (10) of section 1 requires the Board of Medicine to adopt rules to implement the section in consultation with the Board of Osteopathic Medicine. Conversely, subsection (10) of section 2 requires the Board of Osteopathic Medicine to adopt rules to implement the section in consultation with the Board of Medicine.

The bill authorizes physicians to administer stem cell therapies that have not been approved by the FDA. This action may expose physicians to federal regulatory enforcement. If a physician or supplier administers or distributes stem cell products in violation of FDA requirements, the FDA may take a range of enforcement actions, including issuing warning letters, initiating civil or criminal proceedings in coordination with the U.S. Department of Justice, seeking injunctions to prevent continued noncompliance, and disqualifying parties from participating in clinical investigations. In addition, the FDA has authority to issue orders for the retention, recall, destruction, or cessation of manufacturing of human cells, tissues, or cellular- and tissue-based products (HCT/Ps) when it has reasonable grounds to believe the products were manufactured in violation of applicable regulations.

Section 3 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Department of Health through the Board of Medicine and Board of Osteopathic Medicine, would incur rulemaking and implementation costs, which may include staff time for developing criteria for exemption determinations, monitoring compliance, and investigating violations. These costs are likely absorbable within existing resources but could require additional resources depending on volume and enforcement.

The DOH notes that there would be an undeterminable impact on its Bureau of Enforcement (BOE), given that the provisions of the bill do not grant the department authority to inspect facilities to determine compliance with the bill's notice, informed consent, or physical plant requirements.[10] It is anticipated that BOE can absorb the impact with existing resources and budget authority.[11]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates sections 458.3245 and 459.0127 of the Florida Statutes.

[10] *Supra* note 1.
[11] *Id.*

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:
The underlying bill defined "health care providers" as physicians licensed under chs. 458 and 459, F.S. The CS replaces the term "health care providers" with "physicians" and relocates the new section from ch. 456, F.S., which generally applies to all health care practitioners, to chs. 458 and 459, F.S., which apply specifically to allopathic and osteopathic physicians, respectively.

The CS establishes that the Board of Medicine and Board of Osteopathic Medicine must adopt rules to implement the new sections, rather than the DOH. The CS also clarifies that enforcement authority rests with the boards and the DOH, not the Agency for Health Care Administration.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

947004

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
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	.	

The Committee on Health Policy (Trumbull) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 458.3245, Florida Statutes, is created to read:

458.3245 Stem cell therapy.—

(1) The Legislature recognizes the significant potential of stem cell therapies in advancing medical treatments and improving patient outcomes and further recognizes the need to

947004

ensure that such therapies are provided using stem cells obtained in an ethical manner that does not involve stem cells derived from aborted fetuses. It is the intent of the Legislature to foster medical innovation while upholding ethical standards that respect the sanctity of life. By encouraging the use of stem cell sources such as adult stem cells, umbilical cord blood, and other ethically obtained human cells, tissues, or cellular or tissue-based products, the state will advance regenerative medicine in a manner consistent with the values of this state.

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

(a) "Human cells, tissues, or cellular or tissue-based products" means articles containing or consisting of human cells or tissues collected from cord blood donors who are residents of the United States which are intended for implantation, transplantation, infusion, or transfer into a human recipient, including but not limited to, bones, ligaments, skin, dura mater, heart valves, corneas, hematopoietic stem or progenitor cells derived from peripheral and cord blood, manipulated autologous chondrocytes, epithelial cells on a synthetic matrix, and semen or other reproductive tissue. The term does not include any of the following:

1. Vascularized human organs for transplantation.

2. Whole blood or blood components or blood derivative products subject to regulation under part I of chapter 499.

3. Secreted or extracted human products, such as milk, collagen, and cell factors; except that semen is considered a human cell, tissue, or cellular or tissue-based product for purposes of this paragraph.

947004

4. Minimally manipulated bone marrow for homologous use and not combined with another article, except for with water, crystalloids, or a sterilizing, preserving, or storage agent, if the addition of the agent does not raise new clinical safety concerns with respect to the bone marrow.

5. Ancillary products used in the manufacture of human cells, tissues, or cellular or tissue-based products.

6. Cells, tissues, and organs derived from animals other than humans.

7. In vitro diagnostic products.

8. Blood vessels recovered with an organ, as defined in 42 C.F.R. s. 121.2, which are intended for use in organ transplantation and labeled, "For use in organ transplantation only."

9. Fetal-derived stem cells.

10. Adipose-derived mesenchymal stem cells for transplantation.

(b) "Minimally manipulated" means:

1. For structural tissue, processing that does not alter the original relevant characteristics of the tissue relating to the tissue's utility for reconstruction, repair, or replacement.

2. For cells or nonstructural tissues, processing that does not alter the relevant biological characteristics of cells or tissues.

(c) "Physician" means a physician licensed under this chapter or under chapter 459 acting in the course and scope of his or her employment.

(d) "Stem cell therapy" means a treatment involving the use of human cells, tissues, or cellular or tissue-based products.

947004

The term does not include treatment or research using human cells or tissues that were derived from a fetus or an embryo after an abortion.

(3)(a) A physician may perform stem cell therapy that is not approved by the United States Food and Drug Administration if such therapy is used for treatment or procedures that are within the scope of practice for such physician and the therapies are related to orthopedics, wound care, or pain management.

(b) To ensure that the retrieval, manufacture, storage, and use of stem cells used for therapies conducted under this section meet the highest standards, any stem cells used by a physician for therapy provided under this section must be:

1. Manufactured in a clean room space that has been certified by the United States Food and Drug Administration for using high-efficiency particulate air filtration or ultra-low penetration air filtration to minimize nonviable and viable particulate contamination; and

2. Retrieved, manufactured, and stored in a facility that is registered and regulated by the United States Food and Drug Administration and licensed or registered with one of the following entities:

a. National Marrow Donor Program.

b. World Marrow Donor Association.

c. Association for the Advancement of Blood and Biotherapies.

d. American Association of Tissue Banks.

(4) In the performance of any procedure using or purporting to use stem cells or products containing stem cells, the

947004

physician shall adhere to the applicable current good manufacturing practices for the collection, removal, processing, implantation, and transfer of stem cells, or products containing stem cells, pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. ss. 301 et seq.; 52 Stat. 1040 et seq.; and 21 C.F.R. part 1271, Human Cells, Tissues, and Cellular and Tissue-Based Products.

(5) A physician who conducts stem cell therapy pursuant to this section shall provide a patient who is being treated with stem cell therapy with the following written notice before performing the therapy:

THIS NOTICE MUST BE PROVIDED TO YOU UNDER FLORIDA LAW. This physician performs one or more stem cell therapies that have not yet been approved by the United States Food and Drug Administration. You are encouraged to consult with your primary care provider before undergoing any stem cell therapy.

(6) A physician who is required to provide the written notice under subsection (5) shall:

(a) Provide the written notice to a patient on paper that is at least 8.5 inches by 11 inches and printed in no less than 40-point type.

(b) Prominently display the written notice at the entrance to the physician’s office and in an area visible to patients inside such office.

(c) Include the notice in any advertisement for the stem cell therapy. In any form of advertisement, the notice must be

947004

clearly legible and in a font size no smaller than the largest font size used in the advertisement.

(7)(a) A physician required to provide the written notice under subsection (5) must obtain a signed consent form from the patient before performing the stem cell therapy.

(b) The consent form must be signed by the patient or, if the patient is legally not competent, the patient's representative and must state all of the following in language the patient or his or her representative could reasonably be expected to understand:

1. The nature and character of the proposed treatment, including the treatment's United States Food and Drug Administration approval status.

2. The anticipated results of the proposed treatment.

3. The recognized possible alternative forms of treatment.

4. The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment.

(8) This section does not apply to either of the following:

(a) A physician who has obtained approval for an investigational new drug or device from the United States Food and Drug Administration for the use of human cells, tissues, or cellular or tissue-based products.

(b) A physician who performs a stem cell therapy under an employment or other contract on behalf of an institution certified by any of the following:

1. The Foundation for the Accreditation of Cellular Therapy.

947004

2. The Blood and Marrow Transplant Clinical Trials Network.

3. The Association for the Advancement of Blood and Biotherapies.

4. An entity with expertise in stem cell therapy as determined by the department.

(9) A violation of this section may subject the physician to disciplinary action by the board or the department.

(10) The Board of Medicine shall adopt rules in consultation with the Board of Osteopathic Medicine to implement this section.

Section 2. Section 459.0127, Florida Statutes, is created to read:

459.0127 Stem cell therapy.—

(1) The Legislature recognizes the significant potential of stem cell therapies in advancing medical treatments and improving patient outcomes and further recognizes the need to ensure that such therapies are provided using stem cells obtained in an ethical manner that does not involve stem cells derived from aborted fetuses. It is the intent of the Legislature to foster medical innovation while upholding ethical standards that respect the sanctity of life. By encouraging the use of stem cell sources such as adult stem cells, umbilical cord blood, and other ethically obtained human cells, tissues, or cellular or tissue-based products, the state will advance regenerative medicine in a manner consistent with the values of this state.

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

(a) "Human cells, tissues, or cellular or tissue-based products" means articles containing or consisting of human cells

947004

or tissues collected from cord blood donors who are residents of the United States which are intended for implantation, transplantation, infusion, or transfer into a human recipient, including but not limited to, bones, ligaments, skin, dura mater, heart valves, corneas, hematopoietic stem or progenitor cells derived from peripheral and cord blood, manipulated autologous chondrocytes, epithelial cells on a synthetic matrix, and semen or other reproductive tissue. The term does not include any of the following:

1. Vascularized human organs for transplantation.

2. Whole blood or blood components or blood derivative products subject to regulation under part I of chapter 499.

3. Secreted or extracted human products, such as milk, collagen, and cell factors; except that semen is considered a human cell, tissue, or cellular or tissue-based product for purposes of this paragraph.

4. Minimally manipulated bone marrow for homologous use and not combined with another article, except for with water, crystalloids, or a sterilizing, preserving, or storage agent, if the addition of the agent does not raise new clinical safety concerns with respect to the bone marrow.

5. Ancillary products used in the manufacture of human cells, tissues, or cellular or tissue-based products.

6. Cells, tissues, and organs derived from animals other than humans.

7. In vitro diagnostic products.

8. Blood vessels recovered with an organ, as defined in 42 C.F.R. s. 121.2, which are intended for use in organ transplantation and labeled, "For use in organ transplantation

947004

only.”

9. Fetal-derived stem cells.

10. Adipose-derived mesenchymal stem cells for transplantation.

(b) “Minimally manipulated” means:

1. For structural tissue, processing that does not alter the original relevant characteristics of the tissue relating to the tissue’s utility for reconstruction, repair, or replacement.

2. For cells or nonstructural tissues, processing that does not alter the relevant biological characteristics of cells or tissues.

(c) “Physician” means a physician licensed under this chapter or under chapter 458 acting in the course and scope of his or her employment.

(d) “Stem cell therapy” means a treatment involving the use of human cells, tissues, or cellular or tissue-based products. The term does not include treatment or research using human cells or tissues that were derived from a fetus or an embryo after an abortion.

(3)(a) A physician may perform stem cell therapy that is not approved by the United States Food and Drug Administration if such therapy is used for treatment or procedures that are within the scope of practice for such physician and the therapies are related to orthopedics, wound care, or pain management.

(b) To ensure that the retrieval, manufacture, storage, and use of stem cells used for therapies conducted under this section meet the highest standards, any stem cells used by a physician for therapy provided under this section must be:

947004

1. Manufactured in a clean room space that has been certified by the United States Food and Drug Administration for using high-efficiency particulate air filtration or ultra-low penetration air filtration to minimize nonviable and viable particulate contamination; and

2. Retrieved, manufactured, and stored in a facility that is registered and regulated by the United States Food and Drug Administration and licensed or registered with one of the following entities:

a. National Marrow Donor Program.

b. World Marrow Donor Association.

c. Association for the Advancement of Blood and Biotherapies.

d. American Association of Tissue Banks.

(4) In the performance of any procedure using or purporting to use stem cells or products containing stem cells, the physician shall adhere to the applicable current good manufacturing practices for the collection, removal, processing, implantation, and transfer of stem cells, or products containing stem cells, pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. ss. 301 et seq.; 52 Stat. 1040 et seq.; and 21 C.F.R. part 1271, Human Cells, Tissues, and Cellular and Tissue-Based Products.

(5) A physician who conducts stem cell therapy pursuant to this section shall provide a patient who is being treated with stem cell therapy with the following written notice before performing the therapy:

THIS NOTICE MUST BE PROVIDED TO YOU UNDER FLORIDA LAW.

947004

This physician performs one or more stem cell therapies that have not yet been approved by the United States Food and Drug Administration. You are encouraged to consult with your primary care provider before undergoing any stem cell therapy.

(6) A physician who is required to provide the written notice under subsection (5) shall:

(a) Provide the written notice to a patient on paper that is at least 8.5 inches by 11 inches and printed in no less than 40-point type.

(b) Prominently display the written notice at the entrance to the physician's office and in an area visible to patients inside such office.

(c) Include the notice in any advertisement for the stem cell therapy. In any form of advertisement, the notice must be clearly legible and in a font size no smaller than the largest font size used in the advertisement.

(7)(a) A physician required to provide the written notice under subsection (5) must obtain a signed consent form from the patient before performing the stem cell therapy.

(b) The consent form must be signed by the patient or, if the patient is legally not competent, the patient's representative and must state all of the following in language the patient or his or her representative could reasonably be expected to understand:

1. The nature and character of the proposed treatment, including the treatment's United States Food and Drug Administration approval status.

947004

2. The anticipated results of the proposed treatment.

3. The recognized possible alternative forms of treatment.

4. The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment.

(8) This section does not apply to either of the following:

(a) A physician who has obtained approval for an investigational new drug or device from the United States Food and Drug Administration for the use of human cells, tissues, or cellular or tissue-based products.

(b) A physician who performs a stem cell therapy under an employment or other contract on behalf of an institution certified by any of the following:

1. The Foundation for the Accreditation of Cellular Therapy.

2. The Blood and Marrow Transplant Clinical Trials Network.

3. The Association for the Advancement of Blood and Biotherapies.

4. An entity with expertise in stem cell therapy as determined by the department.

(9) A violation of this section may subject the physician to disciplinary action under the rules that have been developed by the board or the department as applicable.

(10) The Board of Osteopathic Medicine shall adopt rules in consultation with the Board of Medicine to implement this section.

Section 3. This act shall take effect July 1, 2025.

947004

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to stem cell therapy; creating ss. 458.3245 and 459.0127, F.S.; providing legislative findings and intent; defining terms; authorizing physicians to perform stem cell therapy not approved by the United States Food and Drug Administration under certain circumstances; specifying requirements for the stem cells that may be used by such physicians; requiring such physicians to adhere to applicable current good manufacturing practices in the performance of such therapies; requiring physicians to provide a specified written notice to patients before performing any stem cell therapy; specifying requirements for the written notice; providing advertisement requirements; requiring physicians to obtain written consent from the patient or his or her representative before performing the therapy; specifying requirements for the consent form; providing applicability; providing for disciplinary action; requiring the Board of Medicine and the Board of Osteopathic Medicine, respectively, to adopt rules in consultation with one another; providing an effective date.

By Senator Trumbull

2-01302C-25 20251768__

A bill to be entitled

An act relating to stem cell therapy; creating s. 456.63, F.S.; providing legislative findings and intent; defining terms; authorizing health care providers to perform stem cell therapy not approved by the United States Food and Drug Administration under certain circumstances; specifying requirements for the stem cells that may be used by such providers; requiring such providers to adhere to applicable current good manufacturing practices in the performance of such therapies; requiring health care providers to provide a specified written notice to patients before performing any stem cell therapy; specifying requirements for the written notice; providing advertisement requirements; requiring health care providers to obtain written consent from the patient or his or her representative before performing the therapy; specifying requirements for the consent form; providing applicability; providing for disciplinary action; requiring the Department of Health to adopt rules; providing an effective date.

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

Section 1. Section 456.63, Florida Statutes, is created to read:

456.63 Stem cell therapy by health care providers; disclosure; informed consent.—

(1) The Legislature recognizes the significant potential of

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

stem cell therapies in advancing medical treatments and improving patient outcomes and further recognizes the need to ensure that such therapies are provided using stem cells obtained in an ethical manner that does not involve stem cells derived from aborted fetuses. It is the intent of the Legislature to foster medical innovation while upholding ethical standards that respect the sanctity of life. By encouraging the use of stem cell sources such as adult stem cells, umbilical cord blood, and other ethically obtained human cells, tissues, or cellular or tissue-based products, the state will advance regenerative medicine in a manner consistent with the values of this state.

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

(a) "Health care provider" means a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 acting in the course and scope of their employment.

(b) "Human cells, tissues, or cellular or tissue-based products" means articles containing or consisting of human cells or tissues collected from cord blood donors who are residents of the United States which are intended for implantation, transplantation, infusion, or transfer into a human recipient, including but not limited to, bones, ligaments, skin, dura mater, heart valves, corneas, hematopoietic stem or progenitor cells derived from peripheral and cord blood, manipulated autologous chondrocytes, epithelial cells on a synthetic matrix, and semen or other reproductive tissue. The term does not include any of the following:

1. Vascularized human organs for transplantation.

2. Whole blood or blood components or blood derivative

products subject to regulation under part I of chapter 499.

3. Secreted or extracted human products, such as milk, collagen, and cell factors; except that semen is considered a human cell, tissue, or cellular or tissue-based product for purposes of this paragraph.

4. Minimally manipulated bone marrow for homologous use and not combined with another article, except for with water, crystalloids, or a sterilizing, preserving, or storage agent, if the addition of the agent does not raise new clinical safety concerns with respect to the bone marrow.

5. Ancillary products used in the manufacture of human cells, tissues, or cellular or tissue-based products.

6. Cells, tissues, and organs derived from animals other than humans.

7. In vitro diagnostic products.

8. Blood vessels recovered with an organ, as defined in 42 C.F.R. s. 121.2, which are intended for use in organ transplantation and labeled, "For use in organ transplantation only."

9. Fetal-derived stem cells.

10. Adipose-derived mesenchymal stem cells for transplantation.

(c) "Minimally manipulated" means:

1. For structural tissue, processing that does not alter the original relevant characteristics of the tissue relating to the tissue's utility for reconstruction, repair, or replacement.

2. For cells or nonstructural tissues, processing that does not alter the relevant biological characteristics of cells or tissues.

(d) "Stem cell therapy" means a treatment involving the use of human cells, tissues, or cellular or tissue-based products. The term does not include treatment or research using human cells or tissues that were derived from a fetus or an embryo after an abortion.

(3)(a) A health care provider licensed in this state may perform stem cell therapy that is not approved by the United States Food and Drug Administration if such therapy is used for treatment or procedures that are within the scope of practice for such provider and the therapies are related to orthopedics, wound care, or pain management.

(b) To ensure that the retrieval, manufacture, storage, and use of stem cells used for therapies conducted under this section meet the highest standards, any stem cells used by a health care provider for therapy provided under this section must be:

1. Manufactured in a clean room space that has been certified by the United States Food and Drug Administration for using high-efficiency particulate air filtration or ultra-low penetration air filtration to minimize nonviable and viable particulate contamination; and

2. Retrieved, manufactured, and stored in a facility that is registered and regulated by the United States Food and Drug Administration and licensed or registered with one of the following entities:

a. National Marrow Donor Program.

b. World Marrow Donor Association.

c. Association for the Advancement of Blood and Biotherapies.

d. American Association of Tissue Banks.

(4) In the performance of any procedure using or purporting to use stem cells or products containing stem cells, the health care provider shall adhere to the applicable current good manufacturing practices for the collection, removal, processing, implantation, and transfer of stem cells, or products containing stem cells, pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. ss. 301 et seq.; 52 Stat. 1040 et seq.; and 21 C.F.R. part 1271, Human Cells, Tissues, and Cellular and Tissue-Based Products.

(5) A health care provider who conducts stem cell therapy pursuant to this section shall provide a patient who is being treated with stem cell therapy with the following written notice before performing the therapy:

THIS NOTICE MUST BE PROVIDED TO YOU UNDER FLORIDA LAW. This health care practitioner performs one or more stem cell therapies that have not yet been approved by the United States Food and Drug Administration. You are encouraged to consult with your primary care provider before undergoing any stem cell therapy.

(6) A health care provider required to provide the written notice under subsection (5) shall:

(a) Provide the written notice to a patient on paper that is at least 8.5 inches by 11 inches and printed in no less than 40-point type.

(b) Prominently display the written notice at the entrance to the health care provider's office and in an area visible to

patients inside such office.

(c) Include the notice in any advertisement for the stem cell therapy. In any form of advertisement, the notice must be clearly legible and in a font size no smaller than the largest font size used in the advertisement.

(7)(a) A health care provider required to provide the written notice under subsection (5) must obtain a signed consent form from the patient before performing the stem cell therapy.

(b) The consent form must be signed by the patient or, if the patient is legally not competent, the patient's representative and must state all of the following in language the patient or his or her representative could reasonably be expected to understand:

1. The nature and character of the proposed treatment, including the treatment's United States Food and Drug Administration approval status.

2. The anticipated results of the proposed treatment.

3. The recognized possible alternative forms of treatment.

4. The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment.

(8) This section does not apply to either of the following:

(a) A health care provider who has obtained approval for an investigational new drug or device from the United States Food and Drug Administration for the use of human cells, tissues, or cellular or tissue-based products.

(b) A health care provider who performs a stem cell therapy under an employment or other contract on behalf of an

institution certified by any of the following:

1. The Foundation for the Accreditation of Cellular Therapy.

2. The Blood and Marrow Transplant Clinical Trials Network.

3. The Association for the Advancement of Blood and Biotherapies.

4. An entity with expertise in stem cell therapy as determined by the department.

(9) A violation of this section may subject the health care provider to disciplinary action under the rules that have been developed by the applicable regulatory board, the department, or the Agency for Health Care Administration, as applicable.

(10) The department shall adopt rules to implement this section.

Section 2. This act shall take effect July 1, 2025.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Health and Human Services, *Chair*
Appropriations
Appropriations Committee on Higher Education
Community Affairs
Health Policy
Judiciary
Rules

SENATOR JAY TRUMBULL
2nd District

March 10, 2025

Re: SB 1768

Dear Chair Burton,

I respectfully request for Senate Bill 1768, relating to Stem Cell Therapy, be placed on the agenda for the next meeting of the Health Policy Committee.

I appreciate your time and consideration of this request. If you have any questions or concerns, please do not hesitate to contact my office at (850) 487-5002.

Thank you,

Senator Jay Trumbull
District 2

REPLY TO:
❒ 840 West 11th Street, Panama City, Florida 32401 (850) 747-5454
❒ 415 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5002

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

Tab 16

The Florida Senate

APPEARANCE RECORD

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

01 Apr 2025
Meeting Date

Health Policy
Committee

1768
Bill Number or Topic

Amendment Barcode (if applicable)

Name Donald Hudspeth - Cord for Life, Inc. Phone 407 839 8333

Address 270 Northlake Blvd. Ste 1012 Email DHudspeth@Cordforlife.com
Street

Altamonte Springs FL 32701
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

4/1/25
Meeting Date

Health Policy
Committee

SB 1768
Bill Number or Topic

Amendment Barcode (if applicable)

Name Aaron DiPietro

Phone 904-608-4471

Address P.O Box 530103
Street

Email aarond@flfamily.org

Orlando FL 32853
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Family Voice

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

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1602
INTRODUCER:	Health Policy Committee and Senator Harrell
SUBJECT:	Health Care Patient Protection
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1602 amends s. 395.1012, F.S., to require each hospital with an emergency department (ED) to develop and implement policies and procedures for pediatric patient care in the ED. Additionally, each such hospital ED must designate a pediatric emergency care coordinator and conduct the National Pediatric Readiness Assessment (NPRA) within a certain time frame.

The bill also amends ss. 395.1055 and 408.05, F.S., to require the AHCA to incorporate the needs of pediatric and neonatal patients in rules requiring an emergency management plan, to adopt rules that establish minimum standards for pediatric patient care in hospital EDs, and to collect the results of the NPRA and publish the overall assessment score for each hospital ED and provide a comparison to the national average score.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Hospital Licensure

Hospitals are regulated by the AHCA under ch. 395, F.S., and the general licensure provisions of part II, of ch. 408, F.S. In Florida, EDs are either located in a hospital or on separate premises of a licensed hospital. Any licensed hospital which has a dedicated ED may provide emergency

services in a location separate from the hospital's main premises, known as a hospital-based off-campus emergency department.[1]

Current law requires each hospital with an ED to screen, examine, and evaluate a patient who presents to the ED to determine if an emergency medical condition exists and, if it does, provide care, treatment, or surgery to relieve or eliminate the emergency medical condition.[2] Each hospital with an ED must provide emergency services and care[3] 24 hours a day and must have at least one physician on-call and available within 30 minutes.[4]

Inventory of Hospital Emergency Services

Each hospital offering emergency services and care must report to the AHCA the services which are within the service capability of the hospital.[5] The AHCA is required to maintain an inventory of hospitals with emergency services, including a list of the services within the service capability of the hospital, to assist emergency medical services providers and the general public in locating appropriate emergency medical care.[6] If a hospital determines it is unable to provide a service on a 24 hour per day, 7 day per week, basis, either directly or indirectly through an arrangement with another hospital, the hospital must request a service exemption from the AHCA.[7]

Policies and Procedures

Each hospital offering emergency services and care is required to maintain written policies and procedures specifying the scope and conduct of their emergency services. The policies and procedures must be approved by the organized medical staff, reviewed at least annually, and must include:

- A process to designate a physician to serve as the director of the ED;
- A written description of the duties and responsibilities of all other health care personnel providing care within the ED;
- A planned formal training program on emergency access laws for all health care personnel working in the ED; and
- A control register to identify all persons seeking emergency care.[8]

Current law does not require EDs to have pediatric-specific policies and procedures.

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[1] Section 395.002(13), F.S.
[2] Section 395.1041, F.S.
[3] Section 395.002(9), F.S., "emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.
[4] Rule 59A-3.255(6)(e), F.A.C.
[5] Section 395.1041(2), F.S.
[6] Medical services listed in the inventory include: anesthesia; burn; cardiology; cardiovascular surgery; colon & rectal surgery; emergency medicine; endocrinology; gastroenterology; general surgery; gynecology; hematology; hyperbaric medicine; internal medicine; nephrology; neurology; neurosurgery; obstetrics; ophthalmology; oral/maxilla-facial surgery; orthopedics; otolaryngology; plastic surgery; podiatry; psychiatry; pulmonary medicine; radiology; thoracic surgery; urology; and vascular surgery.
[7] Rule 59A-3.255(4), F.A.C. AHCA Form 3000-1 Emergency Services Exemption Request
[8] Rule 59A-3.255(6)(e), F.A.C.

Equipment and Supplies

Each hospital ED is required to provide diagnostic radiology services and clinical laboratory services and must ensure that an adequate supply of blood is available at all times. Hospitals EDs are also required to have certain equipment available for immediate use at all times, including:

- Oxygen and means of administration;
- Mechanical ventilatory assistance equipment, including airways, manual breathing bags, and ventilators;
- Cardiac defibrillators with synchronization capability;
- Respiratory and cardiac monitoring equipment;
- Thoracentises and closed thoracotomy sets;
- Tracheostomy or cricothyrotomy sets;
- Tourniquets;
- Vascular cutdown sets;
- Laryngoscopes and endotracheal tubes;
- Urinary catheters with closed volume urinary systems;
- Pleural and pericardial drainage sets;
- Minor surgical instruments;
- Splinting devices;
- Emergency obstetrical packs;
- Standard drugs as determined by the facility;
- Common poison antidotes;
- Syringes, needles, and surgical supplies;
- Parenteral fluids and infusion sets;
- Refrigerated storage for biologicals and other supplies; and
- Stable examination tables.[9]

Currently, there are no pediatric-specific equipment or supply standards for EDs.

Comprehensive Emergency Management Plans

All hospitals are required to develop and adopt a comprehensive emergency management plan for emergency care during an internal or external disaster or an emergency.[10] Each hospital must review, update, and submit its plans annually to the respective county office of emergency management. A hospital's comprehensive emergency management plan must include the following:

- Provisions for the management of staff, including the distribution and assignment of responsibilities and functions;
- Education and training of personnel in carrying out their responsibilities in accordance with the adopted plan;
- Information about how the hospital plans to implement specific procedures outlined in the plan;

[9] Rule 59A-3.255(6)(g), F.A.C.
[10] Section 395.1055(1)(c), F.S.

- Precautionary measures, including voluntary cessation of hospital admissions, to be taken in preparation and response to warnings of inclement weather, or other potential emergency conditions;
- Provisions for the management of patients, including the discharge of patients in the event of an evacuation order;
- Provisions for coordinating with other hospitals;
- Provisions for the individual identification of patients, including the transfer of patient records;
- Provisions to ensure that relocated patients arrive at designated hospitals;
- Provisions to ensure that medication needs will be reviewed and advance medication for relocated patients will be forwarded to the appropriate hospitals;
- Provisions for essential care and services for patients who may be relocated to the facility during a disaster or an emergency, including staffing, supplies, and identification of patients;
- Provisions for the management of supplies, communications, power, emergency equipment, and security;
- Provisions for coordination with designated agencies including the Red Cross and the county emergency management office; and
- Plans for the recovery phase of the operation.[11]

Current law does not require hospitals to include any pediatric-specific provisions in their comprehensive emergency management plans.

Pediatric Care in Hospital Emergency Departments

Children represent approximately 25 percent of all ED visits in the U.S. each year.[12] According to a recent study conducted to evaluate the association between ED pediatric readiness and in-hospital mortality, pediatric patient deaths are 60 percent to 76 percent less likely to occur in an ED with high pediatric readiness. The study included 796,937 pediatric patient visits in 983 EDs over a six-year period (January 1, 2012, through December 31, 2017).

The study used the results of the 2013 National Pediatric Readiness Project Assessment to categorize each hospital ED in one of four levels of pediatric readiness (first quartile 0-58, second quartile 59-72, third quartile 73-87, and fourth quartile 88-100). Hospital EDs with an Assessment score of 88-100 were categorized as having high pediatric readiness. The study also concluded that if all 983 EDs had high pediatric readiness, an estimated 1,442 pediatric deaths may have been prevented.[13]

[11] Rule 59A-3.078, F.A.C.
[12] Remick KE, Hewes HA, Ely M, et al. National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic. *JAMA Netw Open.* 2023. *available at* National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic | Pediatrics | JAMA Network Open | JAMA Network, (last visited Mar. 28, 2025).
[13] Newgard CD, Lin A, Malveau S, et al. *Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care*. JAMA Network (January, 2023) *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800400 (last visited Mar. 28, 2025).

General hospital EDs (nonchildren's hospitals) primarily treat adults and may not be prepared to treat children because of low pediatric patient volume.[14] More than 97 percent of EDs caring for children are general hospital EDs, accounting for 82 percent of pediatric ED visits. Most of these hospitals see less than 15 pediatric patients per day.[15] Therefore, according to a joint policy statement issued by the American Academy of pediatrics (AAP), the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA), "it is imperative that all hospital EDs have the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children."[16]

The 2009 joint policy statement also included guidelines for care of children in the emergency department. In 2012, the Emergency Medical Services for Children (EMSC) Program, under the U.S. Department of Health and Human Services, used the guidelines to launch the National Pediatric Readiness Project, in partnership with the AAP, ACEP, and ENA.[17]

The National Pediatric Readiness Project

The National Pediatric Readiness Project (NPRP) is a quality improvement initiative offering state partnership grants to state governments and accredited schools of medicine to expand and improve emergency medical services for children in hospital EDs.[18] The NPRP measures the performance of hospital EDs based on the following four metrics and includes program goals for each.[19]

- Pediatric Readiness Recognition Programs – Program Goal: To increase the percent of hospitals with an ED recognized through a statewide, territorial, or regional standardized program that are able to stabilize and manage pediatric emergencies.
- Pediatric Emergency Care Coordinators – Program Goal: To increase the percent of hospitals with an ED that have a designated nurse, physician, or both who coordinates pediatric emergency care.
- Disaster Plan Resources – Program Goal: To increase the percent of hospitals with an ED that have a disaster plan that addresses the needs of children.
- Weigh and Record Children's Weight in Kilograms – Program Goal: To increase the percent of hospitals with an ED that weigh and record children in kilograms.

The NPRP particularly focuses on weighing and recording children's weight in kilograms to avoid medication errors. Product labeling for medications with weight-based dosing utilize the

[14] *Id.*
[15] The National Pediatric Readiness Project, Pediatric Readiness Saves Lives, *available at* https://media.emscimprovement.center/documents/EMS220628_ReadinessByTheNumbers_220830_ZekNYVF.pdf (last visited Mar. 28, 2025).
[16] American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement--guidelines for care of children in the emergency department (Oct. 2009), *available at* https://doi.org/10.1542/peds.2009-1807 (last visited Mar. 28, 2025).
[17] *Id.*
[18] The program is also used to improve emergency medical care for children in prehospital settings and to advance family partnerships and leadership in efforts to improve EMSC systems of care, *see* https://www.grants.gov/search-results-detail/340371 (last visited Mar. 28, 2025).
[19] EMSC Innovation and Improvement Center, Performance Measures, *available at* https://emscimprovement.center/programs/partnerships/performance-measures/ (last visited Mar. 28, 2025).

metric system. Converting from pounds to kilograms is an error-prone process and can double the number of dosing errors made. Pediatric and neonatal patients are at greater risk for adverse drug events because they are more vulnerable to the effects of an error.[20]

The National Pediatric Readiness Assessment

Emergency department performance is measured based on the NPRA,[21] a voluntary survey accessed via invitation from the NPRP. The NPRP has conducted two nationwide assessments. The first NPRA occurred in 2013 and the second was in 2021. According to current Program plans, the expectation is that the NPRA will occur every five years, so the next assessment will be in 2026.[22]

Not all hospitals choose to participate in the NPRA. Florida participation rates (58 percent) are below the national average (71 percent), and dropped from 2013 to 2021 (from 61 to 58 percent). Additionally, while over the national average, Florida hospital readiness scores dropped on average between 2013 (78) and 2021 (75).[23, 24]

Florida Emergency Medical Services for Children State Partnership Program

The Florida Emergency Medical Services for Children State Partnership Program[25] (program) is a quality improvement initiative administered by the University of Florida College of Medicine — Jacksonville, and is funded by a state partnership grant from the national EMSC Program.[26] The purpose of the program is to expand and improve emergency medical services for children who need treatment for trauma or critical care by partnering with EDs, emergency medical service agencies, and disaster preparedness organizations to enhance pediatric readiness. The program provides outreach and information to hospital EDs to help improve their pediatric readiness by, among other things, increasing awareness of, and participation in, the NPRP Assessment.

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[20] Emergency Nurses Association, *Weighing all Patients in Kilograms* (2020), *available a*t https://www.pedsnurses.org/assets/docs/Engage/Position-Statements/Weighing%20All%20Patients%20in%20Kilograms%20Final%20Web.pdf *see also* National Coordinating Council for Medication Error Reporting and Prevention, *Recommendations to Weigh Patients and Document Metric Weights to Ensure Accurate Medication Dosing* (Oct. 2018), *available at* https://www.nccmerp.org/recommendations-weigh-patients-and-document-metric-weights-ensure-accurate-medication-dosing-adopted (both last visited Mar. 28, 2025).

[21] National Pediatric Readiness Project, Pediatric Readiness Assessment, *available at* https://www.pedsready.org/home_docs/PedsReady%20Survey-OA%20Assessment.pdf (last visited Mar. 28, 2025).

[22] Emergency Medical Services for Children, National Pediatric Readiness Project Assessment, *available at* https://emscdatacenter.org/sp/pediatric-readiness/national-pediatric-readiness-project-nprp-assessment/ (last visited Mar. 28, 2025).

[23] Florida versus National Pediatric Readiness Project Results from 2013 Survey, *available at* https://www.floridahealth.gov/provider-and-partner-resources/emsc-program/_documents/fl-pediatricreadiness-summary091013.pdf (last visited Mar. 28, 2025).

[24] Florida Versus National Pediatric Readiness Project Results from 2021 Survey, *available at* https://emlrc.org/wp-content/uploads/National-Pediatric-Readiness-Assessment-2021-Results_07.19.2023_Final.pdf (last visited Mar. 28, 2025).

[25] Florida Emergency Medical Services for Children State Partnership Program (Florida PEDREADY), *available at* https://flemsc.emergency.med.jax.ufl.edu/ (last visited Mar. 28, 2025).

[26] EMSC Innovation and Improvement Center, EMSC State Partnership Grants Database, Florida – State Partnership, April 1, 2023 – March 31, 2027, *available at* https://emscimprovement.center/programs/grants/236/florida-state-partnership-20230401-20270331-emsc-state-partnership/ (last visited Mar. 28, 2025).

III. Effect of Proposed Changes:

CS/SB 1602 amends s. 395.1012, F.S., to require each hospital with an ED to:

- Develop and implement policies and procedures for pediatric patient care in the ED which reflect evidence-based best practices relating to, at a minimum:
  - Triage.
  - Measuring and recording vital signs.
  - Weighing and recording weights in kilograms.
  - Calculating medication dosages.
  - Use of pediatric instruments.
- Conduct training at least annually on the policies and procedures developed under this subsection. The training must include, at a minimum:
  - The use of pediatric instruments, as applicable to each licensure type, using clinical simulation as defined in s. 464.003, F.S.
  - Drills that simulate emergency situations. Each ED must conduct drills at least annually.
- Designate a pediatric emergency care coordinator. The pediatric emergency care coordinator must be a physician or a physician assistant licensed under ch. 458 or ch. 459, F.S., a nurse licensed under ch. 464, F.S., or a paramedic licensed under ch. 401, F.S. The pediatric emergency care coordinator is responsible for implementation of and ensuring fidelity to the policies and procedures adopted as required above.
- Conduct the NPRA developed by the NPRP, in accordance with timelines established by the NPRP. The bill also authorizes each hospital with an ED to conduct the NPRP's Open Assessment during a year in which the NPRA is not conducted.

The bill also amends ss. 395.1055 and 408.05, F.S., to require the AHCA to:

- Incorporate the needs of pediatric and neonatal patients in rules requiring an emergency management plan for hospitals and ambulatory surgical centers;
- Adopt rules, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, that establish minimum standards for pediatric patient care in hospital EDs, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies; and
- Collect the results of the NPRA from the Florida Emergency Medical Services for Children State Partnership Program by December 31, 2026, and each December 31 during a year in which the NPRA is conducted; and
- By April 1, 2027, and each April 1 following a year in which the APRA is conducted, publish the overall assessment score for each hospital ED and provide a comparison to the national average score when it becomes available. The bill specifies that only one overall assessment score per hospital, per year, may be collected and published and the comparison must be to the most recently published score.

The bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 1602 may have an indeterminate negative fiscal impact on hospitals related to incorporating additional requirements specific to pediatric readiness in the hospitals' EDs.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.1012, 395.1055, and 408.05.

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:
The CS no longer requires EDs to submit results of the NPRA to the AHCA and instead requires the AHCA to obtain the results from the Florida Emergency Medical Services for Children State Partnership Program. Additionally, the bill authorizes EDs to conduct the NPRP's Open Assessment during years when the NPRA is not conducted and prohibits the AHCA from collecting and publishing more than one assessment score per year for comparison purposes.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

722464

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with directory and title amendments)

Delete lines 55 - 110
and insert:
Readiness Project.

(6) Each hospital with an emergency department may conduct the National Pediatric Readiness Project's Open Assessment during a year in which the National Pediatric Readiness Assessment is not conducted.

Section 2. Present subsections (4) through (19) of section

722464

395.1055, Florida Statutes, are redesignated as subsections (5) through (20), respectively, a new subsection (4) is added to that section, and paragraph (c) of subsection (1) is amended, to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(c) A comprehensive emergency management plan is prepared and updated annually. Such standards must be included in the rules adopted by the agency after consulting with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records, ~~and~~ responding to family inquiries, and the needs of pediatric and neonatal patients. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the

722464

facility of necessary revisions.

(4) The agency, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, shall adopt rules that establish minimum standards for pediatric patient care in hospital emergency departments, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies.

Section 3. Paragraph (n) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(n)1. Collect the overall assessment score of National Pediatric Readiness Assessments conducted by hospital emergency departments pursuant to s. 395.1012(5), from the Florida Emergency Medical Services for Children State Partnership Program by December 31, 2026, and by each December 31 during a year in which the National Pediatric Readiness Assessment is conducted thereafter.

2. By April 1, 2027, and each April 1 following a year in which the National Pediatric Readiness Assessment is conducted thereafter, publish the overall assessment score for each hospital emergency department, and provide a comparison to the national average score when it becomes available.

3. Collect and publish no more than one overall assessment score per hospital, per year, of assessments conducted pursuant

722464

to s. 395.1012(6), and provide a comparison to the hospital emergency department's most recently published score pursuant to subparagraph 2.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:
Delete line 24
and insert:
Section 1. Subsections (5) and (6) are added to section 395.1012,

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:
Delete lines 8 - 19
and insert:
assessments; authorizing a hospital with an emergency department to conduct the National Pediatric Readiness Project's Open Assessment under certain circumstances; amending s. 395.1055, F.S.; requiring the Agency for Health Care Administration to adopt certain rules for comprehensive emergency management plans; requiring the agency, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, to establish minimum standards for pediatric patient care in hospital emergency departments; amending s. 408.05, F.S.; requiring the agency to collect and publish the results of specified assessments submitted by hospitals by specified dates; providing requirements for the collection and

722464

publication of the hospitals' assessment scores;

By Senator Harrell

31-01059A-25 20251602__

A bill to be entitled

An act relating to health care patient protection; amending s. 395.1012, F.S.; requiring hospital emergency departments to develop and implement policies and procedures, conduct training, record weights in a certain manner, designate a pediatric emergency care coordinator, and conduct specified assessments; requiring each hospital emergency department to submit a specified report to the Agency for Health Care Administration by specified dates; amending s. 395.1055, F.S.; requiring the agency to adopt certain rules for comprehensive emergency management plans, and, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, establish minimum standards for pediatric patient care in hospital emergency departments; amending s. 408.05, F.S.; requiring the agency to collect and publish the results of specified assessments submitted by hospitals by specified dates; providing an effective date.

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

Section 1. Subsection (5) is added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

(5)(a) Each hospital with an emergency department must:

1. Develop and implement policies and procedures for pediatric patient care in the emergency department which reflect

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

evidence-based best practices relating to, at a minimum:

a. Triage.

b. Measuring and recording vital signs.

c. Weighing and recording weights in kilograms.

d. Calculating medication dosages.

e. Use of pediatric instruments.

2. Conduct training at least annually on the policies and procedures developed under this subsection. The training must include, at a minimum:

a. The use of pediatric instruments, as applicable to each licensure type, using clinical simulation as defined in s. 464.003.

b. Drills that simulate emergency situations. Each emergency department must conduct drills at least annually.

(b) Each hospital emergency department must:

1. Designate a pediatric emergency care coordinator. The pediatric emergency care coordinator must be a physician or a physician assistant licensed under chapter 458 or chapter 459, a nurse licensed under chapter 464, or a paramedic licensed under chapter 401. The pediatric emergency care coordinator is responsible for implementation of and ensuring fidelity to the policies and procedures adopted under this subsection.

2. Conduct the National Pediatric Readiness Assessment developed by the National Pediatric Readiness Project, in accordance with timelines established by the National Pediatric Readiness Project. Each hospital emergency department shall submit the results of the assessment to the agency by December 31, 2026, and each December 31 during a year in which the National Pediatric Readiness Assessment is conducted thereafter.

Section 2. Subsections (4) through (19) of section 395.1055, Florida Statutes, are renumbered as subsections (5) through (20), respectively, paragraph (c) of subsection (1) is amended, and a new subsection (4) is added to that section to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(c) A comprehensive emergency management plan is prepared and updated annually. Such standards must be included in the rules adopted by the agency after consulting with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records, ~~and~~ responding to family inquiries, and the needs of pediatric and neonatal patients. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review

within 60 days and either approve the plan or advise the facility of necessary revisions.

(4) The agency, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, shall adopt rules that establish minimum standards for pediatric patient care in hospital emergency departments, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies.

Section 3. Paragraph (n) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(n)1. Collect the results of National Pediatric Readiness Assessments submitted by hospitals pursuant to s. 395.1012(5).

2. By April 1, 2027, and each April 1 following a year in which the National Pediatric Readiness Assessment is conducted thereafter, publish the overall assessment score for each hospital emergency department, and provide a comparison to the national average score when it becomes available.

Section 4. This act shall take effect July 1, 2025.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Higher Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

SENATOR GAYLE HARRELL
31st District

March 12, 2025

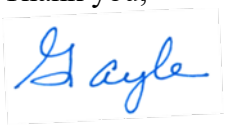
Senator Burton
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Burton,

I respectfully request that SB 1602 – Health Care Patient Protection be placed on the next available agenda for the Health Policy Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,



Senator Gayle Harrell
Senate District 31

Cc: Allen Brown, Staff Director
Anhar Al-Asadi, Committee Administrative Assistant

REPLY TO:
❒ 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
❒ 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

Tab 17

4/1/2021
Meeting Date

The Florida Senate
APPEARANCE RECORD

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

SB 1602
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Jon Cox

Phone 850-544-6[illegible]

Address 230 E Park Ave
Street

Email

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☒ I am a registered lobbyist, representing: Florida Nurses Assn

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1156
INTRODUCER:	Health Policy Committee and Senator Harrell
SUBJECT:	Home Health Aide for Medically Fragile Children Program
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1156 amends s. 400.4765, F.S., related to the Home Health Aide for Medically Fragile Children (HHAMFC) program to:

- Reduce the training required to become a HHAMFC by:
  - Eliminating the requirement that the training program must consist of at least 85 hours of training;
  - Reducing the required minimum number of hours of theoretical nursing instruction from 40 to 20; and
  - Making the required 20 hours of skills training on basic nursing skills and the 16 hours of required clinical training, maximum limits, rather than minimum requirements.
- Specify that the HHAMFC must complete an approved training program and the employing home health agency must provide validation of the HHAMFC prior to providing services to an eligible relative.
- Specify that basic nursing skills training and clinical training must be specific to the child's care needs.
- Increase the Medicaid utilization cap from eight hours per day to 12 hours per day.
- Provide that the $25 per hour Medicaid reimbursement rate is a minimum rate.

- Require the Agency for Health Care Administration (AHCA) to seek federal approval to allow providers to receive reimbursement under the program and to disregard the income earned by a HHAMFC from the program when calculating eligibility for public assistance.[1]

The bill amends s. 400.54, F.S., to require managed care plans to provide the AHCA with data necessary to assess the rate and extent of hospitalizations for children attended by HHAMFCs compared with those attended by a registered nurse (RN) or licensed practical nurse (LPN). The bill requires home health agencies to report adverse incidents within 48 hours of the incident, defines the term "adverse incident," and requires the AHCA to include data on adverse incidents occurring under the care of a HHAMFC in the assessment.

The bill also requires the AHCA to make all necessary requests and submissions to obtain federal approval and initiate any necessary rulemaking within 60 days of the act becoming law.

The provisions of the bill take effect upon the bill becoming a law.

II. Present Situation:

Home Health Aide for Medically Fragile Children Program

The HHAMFC Program was created by the Legislature in 2023, in response to the national health care provider shortage and its impact on medically fragile children and their family caregivers to provide an opportunity for family caregivers to receive training and gainful employment.[2] Other Medicaid programs exist that pay a family member to provide home health services to a Medicaid enrollee, but the HHAMFC Program is the only one that pays a family member who is not a licensed nurse for the provision of home health services to a medically fragile child.

The program allows a family caregiver to be reimbursed by Medicaid as a HHAMFC. To qualify, the care must be provided to a relative who is 21 years old or younger with an underlying physical, mental, or cognitive impairment that prevents him or her from safely living independently. The relative must also be eligible to receive skilled care or respite care services under the Medicaid program.[3] The family caregiver must be at least 18 years old, demonstrate a minimum ability to read and write, and successfully pass background screening requirements. The family caregiver must also complete an approved training program or have graduated from an accredited prelicensure nursing education program and waiting to take the state licensing exam.[4]

The AHCA is required to reimburse a home health agency for services provided by a HHAMFC at a rate of $25 per hour for up to 8 hours per day.[5]

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[1] Section 414.0252, F.S., defines "public assistance" as benefits paid on the basis of the temporary cash assistance, food assistance, Medicaid, or optional state supplementation program.
[2] Chapter 2023-183, Laws of Fla.
[3] Section 400.462(12), F.S.
[4] Section 400.4765(2), F.S.
[5] Section 400.4765(9), F.S.

Training

The AHCA, in consultation with the Board of Nursing, approves HHAMFC training programs developed by home health agencies. A training program must consist of at least 85 hours and include at least 40 hours of theoretical instruction in nursing, 20 hours of skills training on basic nursing, 16 hours of clinical training under the direct supervision of a licensed registered nurse, and an unspecified minimum number of hours of training on HIV/AIDS infections. Additionally, a HHAMFC must obtain and maintain a current certificate in cardiopulmonary resuscitation (CPR) and complete 12 hours of annual in-service training each 12-month period. The training on HIV/AIDS and CPR may be counted towards the 12 hours of in-service training.[6]

The 40 hours of theoretical instruction in nursing must include the following topics:
- Person-centered care;
- Communication and interpersonal skills;
- Infection control;
- Safety and emergency procedures;
- Assistance with activities of daily living;
- Mental health and social service needs;
- Care of cognitively impaired individuals;
- Basic restorative care and rehabilitation;
- Patient rights and confidentiality of personal information and medical records; and
- Relevant legal and ethical issues.

The 20 hours of skills training must consist of basic nursing skills training in the following areas:
- Hygiene, grooming, and toileting;
- Skin care and pressure sore prevention;
- Nutrition and hydration;
- Measuring vital signs, height, and weight;
- Safe lifting, positioning, and moving of patients;
- Wound care;
- Portable oxygen safety and other respiratory procedures;
- Tracheostomy care;
- Enteral care and therapy;
- Peripheral intravenous assistive activities and alternative feeding methods; and
- Urinary catheterization and ostomy care.

A HHAMFC must complete the six hours of training required for home health aides under s. 400.489, F.S., prior to administering medication upon delegation by a registered nurse.

A home health agency must offer training in various formats, and any interactive instruction must be provided during various times of the day. If a HHAMFC allows 24 months to pass without providing any personal care services to an eligible relative, the family caregiver must retake all required training.[7]

[6] Section 400.4765(3), F.S.
[7] Section 400.4765(3)(b), F.S.

Authorized Tasks

A HHAMFC is authorized to perform certain tasks if delegated by a registered nurse, including medication administration and tasks associated with:[8]

- Activities of daily living, including bathing, dressing, eating, maintaining continence, toileting, and transferring;
- Maintaining mobility;
- Nutrition and hydration;
- Assistive devices;
- Safety and cleanliness;
- Data gathering;
- Reporting abnormal signs and symptoms;
- Postmortem care;
- End-of-life care;
- Patient socialization and reality orientation;
- Cardiopulmonary resuscitation and emergency care;
- Residents' or patients' rights;
- Documentation of services performed;
- Infection control;
- Safety and emergency procedures;
- Hygiene and grooming;
- Skin care and pressure sore prevention;
- Wound care;
- Portable oxygen use and safety and other respiratory procedures;
- Tracheostomy care;
- Enteral care and therapy; and
- Peripheral intravenous assistive activities and alternative feeding methods.

Services provided by a HHAMFC must not duplicate private duty nursing services provided to an eligible recipient and must result in a reduction in the number of private duty nursing service hours provided to an eligible recipient.[9]

Annual Assessment Report

The AHCA is required to conduct annual assessments of the HHAMFC Program and report their findings by January 1 of each year to the Governor and the Legislature. The report must include an assessment of caregiver satisfaction with the program, identify additional support that may be needed by HHAMFC's, and assess the rate and extent of the hospitalization of children receiving home health services from a HHAMFC compared to those receiving traditional home health services.

[8] Section 400.462(18), F.S.
[9] Section 400.4765(7), F.S.

Federal Home Health Aide Regulations

Training

Pursuant to the Centers for Medicare & Medicaid Services (CMS) conditions of participation (COPs), a Medicare certified home health agency must ensure that their employees or contractors providing home health aide services comply with federal training and competency requirements.[10]

CMS provides four options to become a qualified home health aide, which include successful completion of:[11]

- A nurse aide training and competency evaluation program approved by the state as meeting the requirements of 42 C.F.R., §§ 483.151 through 483.154, and is in good standing on the state nurse aide registry (this is the option Florida used to implement the HHAMFC Program); or
- A training and competency evaluation program that meets the provisions of 42 C.F.R., § 484.80 (b) and (c); or
- The requirements of a state licensure program that meets the provisions of 42 C.F.R., § 484.80 (b) and (c); or
- A competency evaluation program only that must include certain subject areas.

All of the options, except the competency evaluation program only option, require a minimum of 75 hours of classroom and supervised practical training.[12] A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours.[13]

Competency Evaluation

A home health aide competency evaluation program must address certain subject areas, and a registered nurse must observe the home health aide performing the task with a patient or pseudo-patient.[14] These required subject areas include:[15]

- Communication and interpersonal skills;
- Reading and recording vitals;
- Appropriate and safe techniques in performing personal hygiene and grooming tasks;
- Safe transfer techniques and ambulation; and
- Normal range of motion and positioning.

A home health aide competency evaluation program must also address other subject areas for which a home health aide may be evaluated by written or oral examination, or by a simulated experience with a patient or a pseudo-patient.[16] These required subject areas include:[17]

[10] 42 C.F.R., § 484.80.
[11] 42 C.F.R., § 484.80(a).
[12] 42 C.F.R., § 484.80(b)(1).
[13] 42 C.F.R., § 484.80(b)(2).
[14] 42 C.F.R., § 484.80(c)(1).
[15] 42 C.F.R., § 484.80(b)(3)(i), (iii), (ix), (x), and (xi).
[16] 42 C.F.R., § 484.80(c)(1).
[17] 42 C.F.R., § 484.80(b)(3)(ii), (iv), (v), (vi), (vii), (viii), (xii), (xiii), and (xiv).

- Observation, reporting, and documentation of patient status and the care of service furnished;
- Basic infection prevention and control procedures;
- Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;
- Maintenance of a clean, safe, and health environment;
- Safety and emergency procedures;
- The physical, emotional, and developmental needs of populations served by the home health;
- Adequate nutrition and fluid intake;
- Recognizing and reporting changes in skin condition; and
- Any other task that the home health agency may choose to have an aide perform as permitted under state law.

Medicaid Coverage

Florida Medicaid includes requirements for HHAMFC, referred to as family home health aides in Medicaid, in Rule 59G-4.261, Private Duty Nursing and Family Home Health Aide Services Coverage Policy. Fee-for-service payment rates, procedure codes, and billing units for family home health aide services are specified in Rule 59G-4.002, Provider Reimbursement Schedules and Billing Codes. Currently, the AHCA reimburses for family home health aide servicers at a rate of $25 per hour for a maximum of 8 hours per day for home health agencies that employ parents or caregivers who qualify as HHAMFC.

Family home health aide services can be provided by a related provider, legal guardian, or caretaker relative who is employed by a home health agency. This includes the aunt, brother, brother-in-law, cousin, daughter, daughter-in-law, father, father-in-law, granddaughter, grandfather, grandmother, grandson, great-grandfather, great-grandmother, half-brother, half-sister, husband, mother, mother-in-law, nephew, niece, sister, sister-in-law, son, son-in-law, stepbrother, stepdaughter, stepfather, stepmother, stepsister, stepson, uncle, or wife of the recipient. The home health agency enrolls with Florida Medicaid as a provider type 65 with a specialty 965 to provide family home health aide services if they meet the conditions of participation in Medicare per 42 C.F.R. 440.70. A home health agency wishing to provide private duty nursing services only may enroll with specialty 221. If a home health agency wishes to provide family home health aide and private duty nursing services, it will need both 965 and 221 specialties on its file.

The Florida Department of Children and Families determines financial eligibility for Florida Medicaid. Medicaid is an income-based program, and income earned by a family member providing family home health aide services may impact a recipient's Medicaid eligibility, as well as their eligibility for other types of public assistance. Currently, any income earned by an eligible caregiver employed by a home health agency and providing family home health aide services is reported to DCF as earned income when applying for public assistance, including Medicaid.[18]

[18] AHCA bill analysis for SB 1156, Feb. 27, 2025, (on file with Senate Health Policy Committee staff).

III. Effect of Proposed Changes:

CS/SB 1156 amends s. 400.54, F.S., to require managed care plans to provide the AHCA with data necessary to assess the rate and extent of hospitalizations for children attended by HHAMFCs compared with those attended by a registered nurse (RN) or licensed practical nurse (LPN). The AHCA is also required to include data on adverse incidents occurring under the care of a HHAMFC in the assessment. The bill requires home health agencies to report all adverse incidents occurring under the care of a HHAMFC to the AHCA and the managed care plan within 48 hours after the incident occurs. The bill defines "adverse incident" for reporting purposes to mean:

- Death.
- Brain or spinal damage.
- Permanent disfigurement.
- (Fracture or dislocation of bones or joints.
- A limitation of neurological, physical, or sensory function.
- An event that is reported to law enforcement personnel for investigation.

The bill amends s. 400.4765, F.S., related to the Home Health Aide for Medically Fragile Children (HHAMFC) program to:

- Reduce the training required to become a HHAMFC by:
  - Eliminating the requirement that the training program must consist of at least 85 hours of training;
  - Reducing the required minimum number of hours of theoretical nursing instruction from 40 to 20; and
  - Making the required 20 hours of skills training on basic nursing skills and the 16 hours of required clinical training maximum limits, rather than minimum requirements.
- Specify that before providing services to an eligible relative, a HHAMFC must complete an approved training program. The employing home health agency must provide validation of competency by a registered nurse and maintain documentation of training completion and competency validation.
- Specify that basic nursing skills training and clinical training must be specific to the child's care needs. The employing home health agency must provide additional training and competency validation as the medically fragile child's care needs change and consistent with any changes to the plan of care.
- Increase the Medicaid utilization cap from eight hours per day to 12 hours per day. The bill specifies that if a HHAMFC works more than 40 hours per week, justification must be provided as to why there is no other qualified provider available, and the request must be approved by the home health agency and managed care plan.
- Provide that the $25 per hour Medicaid reimbursement rate is a minimum rate.
- Require the AHCA to, within 30 days after the bill becomes law, seek federal approval through any necessary Medicaid waiver or state plan amendment to:
  - Allow private duty nursing specialty providers and home health services providers to receive reimbursement for services rendered under the program and

- Establish that the income earned by a HHAMFC from the program must be disregarded when calculating eligibility for public assistance.[19]

The bill amends s. 409.903, F.S., to require the AHCA to seek federal approval, including seeking the appropriate federal waiver or state plan amendment, to exclude from the family's countable income any income earned through employment as a home health aide for medically fragile children under s. 400.4765, F.S.

The bill also requires the AHCA to make all necessary requests and submissions to obtain federal approval to implement the amendment made by this act to s. 409.903, F.S., and initiate any necessary rulemaking to implement the amendment made by this act to s. 400.4765, F.S., within 60 days of the act becoming law.

The provisions of the bill take effect upon the bill becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

[19] Section 414.0252, F.S., defines "public assistance" as benefits paid on the basis of the temporary cash assistance, food assistance, Medicaid, or optional state supplementation program.

C. Government Sector Impact:

The AHCA indicates that CS/SB 1156 will have a fiscal impact on the Florida Medicaid program in the amount of $1,569,500 with $671,589 coming from the General Revenue fund.[20]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 400.4765 400.54, and 409.903.

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:
The CS requires home health agencies to report adverse incidents to the AHCA as part of the annual assessment reporting requirements for the home HHAMFC program. The amendment defines "adverse incident" for the purposes of this reporting. The amendment also requires an eligible relative to have completed an approved training program before serving as a HHAMFC and requires the home health agency to provide validation of the HHAMFC's competency. Additionally, the amendment removes the direction to the Division of Law Revision to add the effective date to the act in certain places and adds direction to the AHCA to seek federal approval to implement changes made by the act and initiate rulemaking within 60 days of the act becoming law.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[20] *Supra* n. 18.

735504

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 400.54, Florida Statutes, is amended to read:

400.54 Annual assessment of the home health aide for medically fragile children program.—

(1) The agency shall conduct an annual assessment of the home health aide for medically fragile children program. The

735504

assessment must report caregiver satisfaction with the program, report data on adverse incidents, identify additional support that may be needed by the home health aide for medically fragile children, and assess the rate and extent of hospitalization of children in home health services who are attended by a home health aide for medically fragile children compared to those in home health services provided by a registered nurse or a licensed practical nurse without a home health aide for medically fragile children. Medicaid managed care plans shall provide to the agency data necessary to perform this assessment.

(2) The home health agency shall report all adverse incidents occurring under the care of a home health aide for medically fragile children to the agency and managed care plan within 48 hours after the incident. For purposes of reporting to the agency under this subsection, the term "adverse incident" means any of the following:

(a) Death.

(b) Brain or spinal damage.

(c) Permanent disfigurement.

(d) Fracture or dislocation of bones or joints.

(e) A limitation of neurological, physical, or sensory function.

(f) An event that is reported to law enforcement personnel for investigation.

By January 1 of each year, beginning January 1, 2025, the agency shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 2. Present paragraphs (a) and (b) of subsection (3)

735504

of section 400.4765, Florida Statutes, are redesignated as paragraphs (b) and (c), respectively, a new paragraph (a) is added to that subsection, subsection (10) is added to that section, and present paragraph (a) of subsection (3) and subsection (9) of that section are amended, to read:

400.4765 Home health aide for medically fragile children program.—

(3) TRAINING.—

(a) Before providing services to an eligible relative, a home health aide for medically fragile children must complete an approved training program. The employing home health agency must provide validation of competency by a registered nurse and maintain documentation of training completion and competency validation. The employing home health agency must provide additional training and competency validation as the medically fragile child's care needs change and consistent with any changes to the plan of care.

(b) ~~(a)~~ The agency, in consultation with the Board of Nursing, shall approve home health aide for medically fragile children training programs developed by home health agencies in accordance with 42 C.F.R. ss. 483.151-483.154 and 484.80 to train family caregivers as home health aides for medically fragile children to increase the health care provider workforce and to authorize persons to provide trained nursing services as delegated by a registered nurse to eligible relatives. The program shall include ~~must consist of at least 85 hours of training, including~~, but not be limited to, all of the following:

1. A minimum of 20 ~~40~~ hours of theoretical instruction in

735504

nursing, including, but not limited to, instruction on all of the following:

a. Person-centered care.

b. Communication and interpersonal skills.

c. Infection control.

d. Safety and emergency procedures.

e. Assistance with activities of daily living.

f. Mental health and social service needs.

g. Care of cognitively impaired individuals.

h. Basic restorative care and rehabilitation.

i. Patient rights and confidentiality of personal information and medical records.

j. Relevant legal and ethical issues.

Such instruction must be offered in various formats, and any interactive instruction must be provided during various times of the day.

2. Up to ~~A minimum of~~ 20 hours of skills training on basic nursing skills tailored to the child's care needs as specified in the ordering provider's plan of care and individualized care needs, which may include training on the following topics, as applicable~~, including, but not limited to~~:

a. Hygiene, grooming, and toileting.

b. Skin care and pressure sore prevention.

c. Nutrition and hydration.

d. Measuring vital signs, height, and weight.

e. Safe lifting, positioning, and moving of patients.

f. Wound care.

g. ~~Portable~~ Oxygen use and safety and other respiratory

735504

procedures.

h. Tracheostomy care.

i. Enteral care and therapy.

j. ~~Peripheral~~ Intravenous assistive activities and alternative feeding methods.

k. Urinary catheterization and care and ostomy care.

3. Up to ~~At least~~ 16 hours of clinical training related to the specific needs of the eligible relative under direct supervision of a licensed registered nurse.

4. Training concerning HIV infections and AIDS ~~and is required to obtain and maintain a current certificate in cardiopulmonary resuscitation~~.

5. Obtaining and maintaining a current certificate in cardiopulmonary resuscitation.

(9) FEE SCHEDULE.—The agency shall modify any state Medicaid plans and implement any federal waivers necessary to implement this section and shall establish a Medicaid fee schedule for home health agencies employing a home health aide for medically fragile children at a minimum rate of $25 per hour with a utilization cap of no more than 12 ~~8~~ hours per day and 40 hours per week, per medically fragile child. The utilization cap of 40 hours per week, per recipient may be exceeded; however, justification must be provided as to why there is no other qualified provider available, and the request must be approved by the home health agency and the managed care plan.

(10) FEDERAL APPROVAL.—Within 30 days after the effective date of this act, the agency shall seek federal approval, including seeking the appropriate federal waiver, to:

(a) Allow Medicaid private duty nursing specialty providers



and home health services providers to participate in and receive reimbursement for services rendered under this program.

(b) Provide that the income earned under this program by a home health aide for medically fragile children is disregarded in eligibility considerations for public assistance as defined in s. 414.0252.

Section 3. Subsection (18) of section 400.462, Florida Statutes, is amended to read:

400.462 Definitions.—As used in this part, the term:

(18) "Home health aide for medically fragile children" means a family caregiver who meets the qualifications specified in this part and who performs tasks delegated to him or her under chapter 464 while caring for an eligible relative, and provides care relating to activities of daily living, including those associated with personal care; maintaining mobility; nutrition and hydration; toileting and elimination; assistive devices; safety and cleanliness; data gathering; reporting abnormal signs and symptoms; postmortem care; patient socialization and reality orientation; end-of-life care; cardiopulmonary resuscitation and emergency care; residents' or patients' rights; documentation of services performed; infection control; safety and emergency procedures; hygiene, grooming, skin care, and pressure sore prevention; wound care; ~~portable~~ oxygen use and safety and other respiratory procedures; tracheostomy care; enteral care and therapy; ~~peripheral~~ intravenous assistive activities and alternative feeding methods; and any other tasks delegated to the family caregiver under chapter 464.

Section 4. Paragraph (c) of subsection (1) of section

735504

409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.—The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Families, determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) Low-income families with children are eligible for Medicaid provided they meet the following requirements:

(c) The family's countable income and resources do not exceed the applicable Aid to Families with Dependent Children (AFDC) income and resource standards under the AFDC state plan in effect in July 1996, except as amended in the Medicaid state plan to conform as closely as possible to the requirements of the welfare transition program, to the extent permitted by federal law. The agency shall seek federal approval, including seeking the appropriate federal waiver or state plan amendment, to exclude from the family's countable income any income earned through employment as a home health aide for medically fragile children under s. 400.4765.

Section 5. Within 60 days after this act becomes a law, the Agency for Health Care Administration shall make all necessary requests and submissions to obtain federal approval to implement the amendment made by this act to s. 409.903, Florida Statutes, and initiate any necessary rulemaking to implement the amendment

735504

made by this act to s. 400.4765, Florida Statutes.

Section 6. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to the home health aide for medically fragile children program; amending s. 400.54, F.S.; providing requirements for the annual assessment of the home health aide for medically fragile children program; amending s. 400.4765, F.S.; revising program training requirements; revising the utilization cap of a Medicaid fee schedule; requiring a home health aide for medically fragile children who works more than 40 hours per week to provide specified justification; requiring the Agency for Health Care Administration to seek federal approval, including a federal waiver, for specified purposes; amending s. 400.462, F.S.; conforming provisions to changes made by the act; amending s. 409.903, F.S.; requiring the agency to seek federal approval, including a federal waiver or state plan amendment, for specified purposes; providing construction; providing a directive to the agency to carry out certain tasks within a specified timeframe; providing an effective date.

By Senator Harrell

31-01398B-25 20251156__

A bill to be entitled

An act relating to the home health aide for medically fragile children program; amending s. 400.4765, F.S.; revising the training requirements for family caregivers participating in the program; specifying that services provided by a home health aide for a medically fragile child may not exceed a specified percentage of the total annual hours authorized for private duty nursing services for that child; revising requirements for the Medicaid fee schedule for home health aides for medically fragile children; requiring the Agency for Health Care Administration, within a specified timeframe, to seek federal approval to implement specified practices under the program; amending s. 400.54, F.S.; requiring Medicaid managed care plans to provide certain data to the agency as part of an annual assessment of the home health aide for medically fragile children program; revising requirements for such assessment; providing a directive to the Division of Law Revision; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) and subsection (9) of section 400.4765, Florida Statutes, are amended, and subsection (10) is added to that section, to read:

400.4765 Home health aide for medically fragile children program.—

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(3) TRAINING.—

(a) The agency, in consultation with the Board of Nursing, shall approve home health aide for medically fragile children training programs developed by home health agencies in accordance with 42 C.F.R. ss. 483.151-483.154 and 484.80 to train family caregivers as home health aides for medically fragile children to increase the health care provider workforce and to authorize persons to provide trained nursing services as delegated by a registered nurse to eligible relatives. The program must include ~~consist of at least 85 hours of training, including~~, but need not be limited to, all of the following:

1. A minimum of 20 ~~40~~ hours of theoretical instruction in nursing, including, but not limited to, instruction on all of the following:

a. Person-centered care.

b. Communication and interpersonal skills.

c. Infection control.

d. Safety and emergency procedures.

e. Assistance with activities of daily living.

f. Mental health and social service needs.

g. Care of cognitively impaired individuals.

h. Basic restorative care and rehabilitation.

i. Patient rights and confidentiality of personal information and medical records.

j. Relevant legal and ethical issues.

Such instruction must be offered in various formats, and any interactive instruction must be provided during various times of the day.

2. Up to ~~A minimum of~~ 20 hours of skills training on basic nursing skills, tailored to the child's care needs as specified in the ordering provider's plan of care, which may include training on the following topics, as applicable ~~including, but not limited to~~:

a. Hygiene, grooming, and toileting.

b. Skin care and pressure sore prevention.

c. Nutrition and hydration.

d. Measuring vital signs, height, and weight.

e. Safe lifting, positioning, and moving of patients.

f. Wound care.

g. ~~Portable~~ Oxygen use and safety and other respiratory procedures.

h. Tracheostomy care.

i. Enteral care and therapy.

j. ~~Peripheral~~ Intravenous assistive activities and alternative feeding methods.

k. Urinary catheterization and care and ostomy care.

3. Up to ~~At least~~ 16 hours of clinical training related to the specific needs of the eligible relative, under direct supervision of a licensed registered nurse.

4. Training concerning HIV infections and AIDS. ~~and is required to obtain and maintain~~

5. Obtaining and maintaining a current certificate in cardiopulmonary resuscitation.

(9) FEE SCHEDULE.—The agency shall modify any state Medicaid plans and implement any federal waivers necessary to implement this section and shall establish a Medicaid fee schedule for home health agencies employing a home health aide

for medically fragile children at a minimum rate of $25 per hour with a utilization cap of no more than 12 ~~8~~ hours per day per medically fragile child. If a home health aide for medically fragile children works more than 40 hours per week, justification must be provided as to why there is no other qualified provider available, and the request must be approved by the home health agency and the managed care plan.

(10) FEDERAL APPROVAL.—Within 30 days after this act becomes a law, the agency shall seek federal approval through any necessary Medicaid waiver or state plan amendment to:

(a) Allow Medicaid private duty nursing specialty providers and home health services providers to participate in and receive reimbursement for services rendered under the program.

(b) Establish that the income earned under the program by a home health aide for medically fragile children must be disregarded in eligibility considerations for public assistance as defined in s. 414.0252.

Section 2. Section 400.54, Florida Statutes, is amended to read:

400.54 Annual assessment of the home health aide for medically fragile children program.—The agency shall conduct an annual assessment of the home health aide for medically fragile children program. The assessment must report caregiver satisfaction with the program and~~,~~ identify additional support that may be needed by the home health aide for medically fragile children. The managed care plan shall provide to the agency the data necessary to~~, and~~ assess the rate and extent of hospitalization of children in home health services who are attended by a home health aide for medically fragile children

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

compared to those in home health services provided by a registered nurse or licensed practical nurse without a home health aide for medically fragile children. The agency shall include in the assessment data on any adverse incident occurring under the care of a home health aide for medically fragile children. By January 1 of each year, beginning January 1, 2025, the agency shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 3. The Division of Law Revision is directed to replace the phrase "this act becomes a law" wherever it occurs in this act with the date this act becomes a law.

Section 4. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Higher Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

SENATOR GAYLE HARRELL
31st District

March 7, 2025

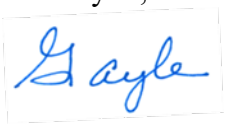
Senator Burton
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Burton ,

I respectfully request that SB 1156 – Home Health Aide for Medically Fragile Children Program be placed on the next available agenda for the Health Policy Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,



Senator Gayle Harrell
Senate District 31

Cc: Allen Brown, Staff Director
Anhar Al-Asadi, Committee Administrative Assistant

REPLY TO:
❒ 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
❒ 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

Tab 18

The Florida Senate
APPEARANCE RECORD

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

4-1-2025
Meeting Date

Health Policy
Committee

SB 1156
Bill Number or Topic

Amendment Barcode (if applicable)

Name Margaret J. Hooper

Phone 850-294-0052

Address 124 Marriott Drive #203
Street

Email MargaretD@FDDC.org

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Developmental Disabilities Council

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

APRIL 1, 2025
Meeting Date

Committee

SB 1156
Bill Number or Topic

Home Health Aid for Medically FRAgile Children
Amendment Barcode (if applicable)

Name Tanya Jackson

Phone 850 445 0107

Address 113 E College
Street

Email Tanya@Pinpointresults.com

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

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

Team Select and Angels of Care

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1490
INTRODUCER:	Health Policy Committee and Senator Harrell
SUBJECT:	Children's Medical Services Program
DATE:	April 3, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1490 transfers the operation of the Children's Medical Services (CMS) Managed Care Plan from the Florida Department of Health (DOH) to the Florida Agency for Health Care Administration (AHCA).

Under the bill, the DOH will retain responsibility for clinical eligibility determinations and must provide ongoing consultation to the AHCA on services to children and youth with special health care needs.

The bill repeals s. 391.037, F.S., effective January 1, 2026, deleting provisions that clarify instances in which it is not a violation of s. 112.313(7), F.S., for a physician who is involved with the DOH under certain circumstances to also be employed by the DOH to provide CMS services or services to assist in proceedings related to children.

The bill requires the AHCA to develop a plan to redesign the Florida Medicaid Model Waiver for home and community-based services (HCBS)[1] to include children who receive private duty

[1] HCBS are types of person-centered care delivered in the home and community. A variety of health and human services can be provided, including home health care, durable medical equipment, case management, personal care, and caregiver and client training. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care; *see* CMS.gov, *Home- and Community-Based Services, available at*

nursing (PDN) services. The bill also requires the AHCA to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by September 30, 2025, detailing certain aspects of the waiver redesign.

The bill takes effect upon becoming law, except as otherwise expressly provided.

II. Present Situation:

Florida Agency for Health Care Administration

The Florida Agency for Health Care Administration (AHCA) was statutorily created by ch. 20, F.S., as the chief health policy and planning entity for the state. The AHCA is primarily responsible for the state's estimated $35 billion Medicaid program (which is projected to serve 4.7 million Floridians in state fiscal year 2024-2025), the licensure of the state's more than 50,500 health care facilities, and the sharing of health care data through the Florida Center for Health Information and Policy Analysis.[2]

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[3] The federal Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services (HHS) is responsible for administering the Medicaid program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians and is financed through state and federal funds.[4]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.[5]

Florida KidCare – The Children's Health Insurance Program

Florida KidCare is the state's children's health insurance program (CHIP) for uninsured children who meet income and eligibility requirements. In 1998, the Florida Legislature created Florida KidCare in response to the passage of Title XXI of the Social Security Act (SSA) in 1997. Three state agencies[6] and the Florida Healthy Kids Corporation, a non-profit organization, form the Florida KidCare partnership. MediKids, Florida Healthy Kids, and Title XXI CMS Managed Care Plan compose Florida KidCare. Florida KidCare is not an entitlement program, and the

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https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services (last visited Mar. 30, 2025).

[2] Florida Agency for Health Care Administration, *About the Agency for Health Care Administration, available at* https://ahca.myflorida.com/about-the-agency-for-health-care-administration (last visited Mar. 30, 2025).

[3] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid (last visited Mar. 30, 2025).

[4] Section 20.42, F.S.

[5] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid-state-planamendments/index.html (last visited Mar. 30, 2025).

[6] The AHCA, the Florida Department of Children and Families (DCF), and the DOH.

families pay a monthly premium that varies depending on the family's income. Florida KidCare also includes Medicaid for children.[7]

Statewide Medicaid Managed Care

Approximately 72.5 percent of Florida Medicaid recipients[8] receive services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[9] The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and the Prepaid Dental Health program.[10] Among these three components, Florida's SMMC program offers a health care package covering acute, preventive, behavioral health, prescribed drugs, long-term care, and dental services. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973, 409.98, and 409.9855, F.S.[11]

The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in 2014 and was re-procured for a period beginning December 2018 and ending in 2023.[12] In 2020, the Legislature extended the allowable term of the SMMC contracts from five to six years.[13] As a result, the AHCA's previous contracts recently ended in December 2024. On February 1, 2025, the AHCA implemented new SMMC contracts, and the contractual period runs through 2030.[14]

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[7] Florida Agency for Health Care Administration, *Florida KidCare – Title XXI – Children's Health Insurance Program (CHIP), available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/program-policy/florida-kidcare-title-xxi-children-s-health-insurance-program-chip (last visited Mar. 30, 2025).

[8] The other 27.5 percent of recipients receive Medicaid services through the fee-for-service (FFS) delivery model, where providers contract directly with the AHCA to render services, billing and receiving reimbursement directly from the AHCA; Florida Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).

[9] Florida Agency for Health Care Administration, *Florida Statewide Medicaid Enrollment Report As of February 28, 2025 (including Medikids Population), available at* https://ahca.myflorida.com/content/download/26230/file/ENR_202502.xls (last visited Mar. 30, 2025).

[10] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited Mar. 27, 2025).

[11] Florida Agency for Health Care Administration, *Senate Bill 1490* (Nov. 4, 2024) (on file with Senate Committee on Health Policy).

[12] Agency for Health Care Administration, *Statewide Medicaid Managed Care: Overview, available at* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/SMMC_Overview_12042018.pdf (last visited Mar. 30, 2025).

[13] Chapter 2020-156, s. 44, Laws of Florida.

[14] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care 3.0 Overview, available at* https://ahca.myflorida.com/content/download/25090/file/Statewide%20Medicaid%20Managed%20Care%20Full%20Deck_09172024.pdf (last visited Mar. 30, 2025).

Florida Medicaid Waivers

State Medicaid programs may request a formal waiver of the requirements codified in the federal Social Security Act. Federal waivers give states flexibility not afforded through their Medicaid state plan. Of the available waiver types,[15,16] Florida's current Medicaid waivers are as follows:[17]

- Section 1115 – Research & Demonstration Projects[18]
  - 1115 Florida MMA Waiver[19]
  - 1115 Florida Medicaid Family Planning Waiver[20]
- Section 1915(b) – Managed Care Waivers[21]
  - 1915(b)(1)(4) Florida Non-Emergency Transportation (NET) Waiver[22]
- Concurrent Section 1915(b) and 1915(c)[23] Waivers
  - 1915(b)(c) Florida LTC Managed Care Waiver[24]

[15] Medicaid.gov, *Managed Care Authorities, available at* https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities (last visited Mar. 30, 2025).
[16] Medicaid.gov, *Home & Community Based Services Authorities, available at* https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities (last visited Mar. 30, 2025).
[17] Florida Agency for Health Care Administration, *2025 Agency Legislative Bill Analysis – Senate Bill 1490* (Nov. 4, 2024) (on file with Senate Committee on Health Policy).
[18] Section 1115 of the SSA gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches, such as expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible, providing services not typically covered by Medicaid, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs; *see* Medicaid.gov, *Managed Care Authorities, available at* https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities (last visited Mar. 30, 2025).
[19] The MMA program provides primary and acute medical care, and behavioral health and dental services for the majority of Medicaid recipients. Recipients receive their services through competitively selected health plans; see Florida Agency for Health Care Administration, *Federal Waivers, available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers (last visited Mar. 30, 2025).
[20] The family planning waiver provides family planning and family planning-related services to all women of childbearing age (14-55) losing Medicaid coverage, who have a family income at or below 191 percent of the federal poverty level and who are not otherwise eligible for Medicaid, CHIP, or other health insurance coverage providing family planning services. Coverage is available for up to two years after loss of Medicaid eligibility; *see* Florida Agency for Health Care Administration, *Federal Waivers, available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers (last visited Mar. 30, 2025).
[21] States can also implement a managed care delivery system using waiver authority under 1915(b) of the SSA. There are four 1915(b) waivers: (b)(1) Freedom of Choice - restricts Medicaid enrollees from receiving services within the managed care network; (b)(2) Enrollment Broker - utilizes a "central broker;" (b)(3) Non-Medicaid Services Waiver - uses cost savings to provide additional services to beneficiaries; and (b)(4) Selective Contracting Waiver - restricts the provider from whom the Medicaid eligible may obtain services. *See* Medicaid.gov, *Managed Care Authorities, available at* https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities (last visited Mar. 30, 2025).
[22] The Florida NET waiver provides NET services to eligible Medicaid recipients; see Florida Agency for Health Care Administration, *FL 1915(b) Managed Care Waiver, available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/fl-1915-b-managed-care-waiver (last visited Mar. 30, 2025).
[23] The Medicaid HCBS waiver program is authorized in s. 1915(c) of the SSA. The program permits a state to furnish an array of HCBS that assist Medicaid beneficiaries to live in the community and avoid institutionalization; *see* CMS Waiver Applications, *1915(c) Waiver Application & 372 Reports, available at* https://wms-mmdl.cms.gov/WMS/faces/portal.jsp (last visited Mar. 30, 2025).
[24] The LTC program provides LTC services and supports to eligible disabled individuals aged 18-64 and elderly individuals aged 65 or older, including individuals over the age of 18 with a diagnosis of cystic fibrosis, AIDS, or a traumatic brain or spinal cord injury. Program recipients receive their services through competitively selected managed care organizations; *see* Florida Agency for Health Care Administration, *Federal Waivers, available at*

- Concurrent Section 1915(a)[25] and 1915(c) Waivers
  - 1915(a)(c) Florida Comprehensive Intellectual and Developmental Disabilities Managed Care (IDD Pilot) Waiver[26]
- Section 1915(c) - HCBS Waivers
  - 1915(c) Florida Developmental Disabilities Individual Budgeting (iBudget) Waiver[27]
  - 1915(c) Florida Familial Dysautonomia (FD) Waiver[28]
  - 1915(c) Florida Model Waiver

The Florida Medicaid Model Waiver

The current 1915(c) Model waiver was implemented in 1991, and it is authorized under s. 409.906, F.S., and Rule 59G-13.080, F.A.C. The waiver provides HCBS to eligible children and is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while living at home in their community. The Model Waiver is a Katie Beckett Waiver, also known as the federal Tax Equity and Fiscal Responsibility Act (TEFRA) waiver, which permits the state to disregard the family income for certain children when determining eligibility for the waiver (also commonly referred to as "family of one").[29]

The current eligibility criteria for the Model waiver require that eligible individuals must be:[30]

- 20 years of age or younger;
- Determined disabled using criteria established by the federal Social Security Administration;
- Determined at-risk for hospitalization by the Children's Multidisciplinary Assessment Team (CMAT); and

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https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers (last visited Mar. 30, 2025).

[25] States can implement a voluntary managed care program simply by executing a contract with companies that the state has procured using a competitive procurement process. The Centers for Medicare & Medicaid Services must approve the state in order to make payment. Currently, 13 states (and Puerto Rico) use 1915(a) contracts to administer 24 voluntary managed care programs; *see* Medicaid.gov, *Managed Care Authorities*, *available at* https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities (last visited Mar. 30, 2025).

[26] The IDD Pilot Waiver is a voluntary, comprehensive program consisting of MMA, LTC waiver, and Florida Developmental Disabilities Individual Budgeting (iBudget) waiver services; *see* Florida Agency for Health Care Administration, *Comprehensive Intellectual and Developmental Disabilities Managed Care Waiver*, *available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/comprehensive-intellectual-and-developmental-disabilities-managed-care-waiver (last visited Mar. 30, 2025).

[27] The purpose of the Medicaid iBudget waiver is to provide home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting utilizing an individual budgeting approach, and to provide enhanced opportunities for self-determination; *see* Florida Agency for Health Care Administration, *Developmental Disabilities Individual Budgeting (iBudget) Waiver*, *available at* https://ahca.myflorida.com/medicaid/home-and-community-based-settings-rule/developmental-disabilities-individual-budgeting-ibudget-waiver (last visited Mar. 30, 2025).

[28] The FD waiver is designed to promote, maintain, and restore the health of eligible recipients with FD and to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent hospital placement or institutionalization; *see* Florida Agency for Health Care Administration, *Familial Dysautonomia Waiver*, *available at* https://ahca.myflorida.com/medicaid/home-and-community-based-settings-rule/familial-dysautonomia-waiver (last visited Mar. 30, 2025).

[29] Florida Agency for Health Care Administration, *Medicaid 2025 General Session CMS Transfer Briefing* (Feb. 19, 2025) (on file with Senate Committee on Health Policy).

[30] Florida Agency for Health Care Administration, *Model Waiver*, *available at* https://ahca.myflorida.com/medicaid/home-and-community-based-settings-rule/model-waiver (last visited Mar. 30, 2025).

- Diagnosed as having degenerative spinocerebellar disease or deemed medically fragile and have resided in a skilled nursing facility for at least 60 consecutive days prior to enrollment.

The Model waiver currently has 20 enrollment slots available of which five are for children in the community with degenerative spinocerebellar disease and 15 are for children deemed medically fragile that have resided in a skilled nursing facility for at least 60 consecutive days. Currently, the enrollment slots do not include children that receive private duty nursing (PDN) services who do not have degenerative spinocerebellar disease.[31] Model waiver services include environmental accessibility adaptations, nursing home transition services, and respite care.[32]

Services to Medically Fragile Children

PDN services are medically necessary skilled nursing services that may be provided to recipients under the age of 21 years in their home or community to support the care required by their complex medical condition, illness, or injury. Florida Medicaid covers PDN services under the state plan. There are approximately 3,000 Medicaid-eligible children currently receiving PDN services for a variety of medical conditions.[33] Under the Florida Medicaid PDN and Family Home Health Aide Services Coverage Policy,[34] PDN services are provided by a licensed practical nurse or a registered nurse licensed in accordance with ch. 464, F.S., working within the scope of his or her practice and employed by home health agencies licensed in accordance with ss. 400.464 and 408.810, F.S., and rule chs. 59A-8 and 59A-35, F.A.C.

During Florida's 2023 Legislative Session, HB 391, titled Home Health Aides for Medically Fragile Children, was enacted. The bill authorized home health agencies to employ and train a family caregiver of an eligible relative to be a home health aide for eligible medically fragile children. Additionally, the bill directed the AHCA to establish a Medicaid fee schedule for home health agencies employing a home health aide for medically fragile children at $25 per hour with a utilization cap of no more than eight hours per day. To implement this requirement, the AHCA amended Rule 59G-4.261, F.A.C., Florida Medicaid PDN and Family Home Health Aide Services, effective October 1, 2024.[35]

On July 14, 2023, a federal court order of injunction was entered in *United States v. Florida*, No. 12-60460-CV (S.D.Fla.). The injunction outlines the requirements of the state to comply with three main orders:[36]

- Require Medicaid managed care plans to ensure the provision of all covered and authorized PDN services and develop methods to measure provider performance, including real-time reporting of PDN provider issues;
- Inform and facilitate the transition of children from nursing facilities; and

[31] *Supra* note 29.
[32] *Supra* note 30.
[33] *Supra* note 29.
[34] Florida Agency for Health Care Administration, *Florida Medicaid Private Duty Nursing and Family Home Health Aide Services Coverage Policy* (Sep. 2024), *available at* https://ahca.myflorida.com/content/download/7036/file/59G-4.261%20Private%20Duty%20Nursing%20Services%20Coverage%20Policy_FINAL.pdf (last visited Mar. 30, 2025).
[35] *Supra* note 29.
[36] *Id*.

- Improve the existing Care Coordination system to strengthen accountability and eliminate silos of care.

The injunction requires that 90 percent of PDN be provided for children receiving 24/7 PDN and 70 percent of PDN for all other children prior authorized to receive PDN.[37]

Under the state plan, Florida Medicaid does not currently offer children receiving PDN services respite or home modifications.[38]

Florida Department of Health

The Florida Department of Health (DOH) is responsible for the state's public health system, which must be designed to promote, protect, and improve the health of all people in the state.[39]

The DOH's Division of Children's Medical Services

The DOH's Division of Children's Medical Services (CMS) is a collection of programs serving children with special health care needs, including the:

- Child Abuse Death Review Unit;[40]
- Child Protection Teams;[41]
- CMS Managed Care Plan;
- CMAT;[42]
- Early Steps;[43]
- Medical Foster Care Program;[44]

[37] *Id*.
[38] *Id*.
[39] Section 381.001, F.S.
[40] The DOH's Division of CMS, Bureau of Child Protection and Special Technologies, Child Abuse Death Review (CADR) Unit, administers the CADR system, which utilizes local CADR committees to conduct comprehensive evaluations of the circumstances surrounding child fatalities reported to the DCF's Florida Abuse Hotline and accepted for investigation; *see* Florida Department of Health, *Child Abuse Death Review*, *available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/cadr/index.html (last visited Mar. 30, 2025). *See also* s. 383.402, F.S.
[41] The Child Protection Teams, as mandated by s. 39.303, F.S., assist the DCF and local Sheriff's offices responsible for child protective investigations to assess allegations of abuse and neglect through the provision of multidisciplinary assessments, including medical evaluations and other clinical assessments; see Florida Department of Health, *Child Protection*, *available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/Child-Protection/index.html (last visited Mar. 30, 2025).
[42] When a child or youth under 21 years of age has a serious or complex medical condition that may require LTC services, the CMAT may review the medical and psychosocial assessment and make a medically necessary determination of eligibility for Medicaid funded LTC services; *see* Florida Department of Health, *Children's Multidisciplinary Assessment Team (CMAT)*, *available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/cmat/index.html (last visited Mar. 30, 2025).
[43] Early Steps is Florida's early intervention system that offers services to eligible infants and toddlers, age birth to 36 months, who have or are at-risk for developmental disabilities or delays; *see* Florida Department of Health, *Early Steps*, *available at* https://www.floridahealth.gov/programs-and-services/childrens-health/early-steps/index.html (last visited Mar. 30, 2025).
[44] The Medical Foster Care Program is facilitated through the DOH, providing foster children with medical conditions an opportunity to receive care within a family setting; see Florida Department of Health, *Medical Foster Care*, *available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/medical-foster-care/index.html (last visited Mar. 30, 2025).

- Newborn Screening Program;[45]
- Poison Information Center Network;[46]
- Regional Perinatal Intensive Care Centers Program;[47]
- Safety Net Program;[48]
- Sexual Abuse Treatment Program;[49] and
- Title V Program.[50]

The DOH's Division of CMS, also known as the CMS program, is statutorily authorized to operate the CMS Managed Care Plan for children with special health care needs[51] for Florida KidCare and Medicaid.[52]

[45] Newborns are screened for certain genetic, endocrine, hemoglobinopathy, immunologic, and metabolic conditions. Screenings for hearing loss and critical congenital heart defects are completed prior to discharge from a hospital or birth facility. Florida screens for 37 core conditions and may detect an additional 23 secondary conditions (a total of 60 conditions); *see* Florida Newborn Screening, *For Parents, available at* https://floridanewbornscreening.com/ (last visited Mar. 30, 2025).

[46] The DOH's Division of CMS contracts with the three certified regional poison control centers, located in Jacksonville (North), Tampa (Central), and Miami (South), which comprise the Florida Poison Information Center Network. These centers operate under the oversight of the CMS program and are responsible for the provision of toll-free access to poison information for the public; the management of poison cases; offering professional consultation to healthcare practitioners; delivering prevention education to the public; and collecting and reporting poison-related data. *See* s. 395.1027, F.S. See also Florida Department of Health, *Child Protection, Florida Poison Control Center, available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/Child-Protection/index.html (last visited Mar. 30, 2025).

[47] The Regional Perinatal Intensive Care Centers work to improve the outcome of pregnancy and the quality of life from birth. These centers provide obstetrical services to women who have a high-risk pregnancy and care for newborns with special health needs, such as critical illness or low birth weight; see Florida Department of Health, *Regional Perinatal Intensive Care Centers (RPICC) Program, available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/regional-perinatal-intensive-care-centers-program/index.html (last visited Mar. 30, 2025).

[48] The CMS Safety Net Program helps pay for some medically necessary health services and family needs. Safety Net serves children with chronic and serious health conditions who do not qualify for Florida Medicaid or KidCare, or are unable to access services; *see* Florida Department of Health, *Safety Net Program, available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/safety-net/index.html (last visited Mar. 30, 2025).

[49] The CMS Sexual Abuse Treatment Program provides a combination of group, family, and individual counseling for child sexual abuse survivors and their families to reduce the trauma caused by the child sexual victimization, assist the family to recover from the victimization, prevent further child sexual victimization from occurring, and enable families to have healthy, non-abusive relationships; see Florida Department of Health, *Child Protection, Sexual Abuse Treatment Programs, available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/Child-Protection/index.html (last visited Mar. 30, 2025).

[50] Florida's Title V Program, the Maternal and Child Health program and the Youth with Special Health Care Needs program, supports statewide public health efforts to protect, promote, and improve the health of children and young adults with chronic and serious physical, developmental, behavioral, or emotional conditions through a comprehensive system of care; see Florida Department of Health, *CMS Title V Program, available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/title-5-program/index.html (last visited Mar. 30, 2025).

[51] "Children with special health care needs" means those children younger than 21 years of age who have chronic and serious physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children; s. 391.021(2), F.S.

[52] Part I, of ch. 391, F.S.

The CMS Managed Care Plan

The CMS Network[53] was established to provide children with special health care needs with a family-centered, comprehensive, and coordinated statewide managed system of care and to provide essential preventative, evaluative, and early intervention services for children at risk for or having special health care needs. Originally, the CMS Network was an FFS program serving children with special health care needs who were enrolled in either Medicaid or Florida KidCare.[54]

In August 2014, the CMS Network was transitioned to a managed care model within the AHCA and became known as the CMS Managed Care Plan. The AHCA contracts with the DOH to administer the CMS Managed Care Plan, and the DOH subsequently subcontracts with a health maintenance organization[55] to provide managed medical services to CMS Managed Care Plan enrollees. The DOH conducts clinical eligibility determinations for the CMS Managed Care Plan and provides vendor oversight into the areas of clinical operations, compliance, performance management, family level grievance remedies, and provider technical assistance.[56]

Currently, the DOH sends invoices for CMS Managed Care Plan services to the AHCA for payment, often causing delays. At present, Florida law has not been updated to reflect the change from the CMS Network to the CMS Managed Care Plan; however, the word "network" is used interchangeably with the CMS Managed Care Plan.[57]

Enrollment in the CMS Managed Care Plan has continually increased. In May 2024, the CMS Managed Care Plan provided services to 90,207 Medicaid and 11,458 Florida KidCare enrolled members.[58]

III. Effect of Proposed Changes:

Section 1 creates a non-statutory section of the Laws of Florida to transfer all statutory powers, duties, functions, records, personnel, pending issues, existing contracts, administrative authority, administrative rules, and unexpended balances of appropriations, allocations, and other funds for the operation of the DOH's CMS Managed Care Plan to the AHCA effective July 1, 2025.

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[53] "Children's Medical Services network" or "network" means a statewide managed care service system that includes health care providers (a health professional, health care facility, or entity licensed or certified to provide health services in this state that meets the criteria as established by the DOH); *see* s. 391.021, F.S.

[54] Florida Agency for Health Care Administration, *2025 Agency Legislative Bill Analysis – Senate Bill 1490* (Nov. 4, 2024) (on file with Senate Committee on Health Policy).

[55] Health maintenance organization (HMO) plans offer a wide range of health care services through a network of providers. An HMO gives subscribers access to certain doctors, hospitals and other providers within its network. The network consists of providers who agreed to supply services to subscribers for pre-negotiated rates, as well as meet certain quality standards. Unlike some other insurance plan types, care is covered only if a subscriber sees a provider within the HMO's network, except in the case of an emergency; *see* Florida Department of Financial Services, *Health Insurance and Health Maintenance Organizations – a guide for consumers, available at* https://myfloridacfo.com/docs-sf/consumer-services-libraries/consumerservices-documents/understanding-coverage/consumer-guides/health-insurance-guide.pdf?sfvrsn=5546b2b_4 (last visited Mar. 30, 2025). *See also* s. 641.19(12), F.S.

[56] *Supra* note 58.

[57] *Id*.

[58] *Id*.

The bill indicates that the transfer of operations of the CMS Managed Care Plan does not affect the validity of any judicial or administrative action pending as of 11:59 p.m., on the day before the effective date of the transfer to which the DOH's CMS Managed Care Plan is at that time a party, and that the AHCA must be substituted as a party in interest in any such action.

The bill requires the DOH's CMS program to collaborate with the AHCA in the care of children and youth with special health care needs. The DOH's CMS program must:

- Conduct clinical eligibility screening for children and youth with special health care needs who are eligible for or enrolled in Medicaid or CHIP.
- Provide ongoing consultation to the AHCA to ensure high-quality, family-centered, coordinated health services within an effective system of care for children and youth with special health care needs.

Section 2 amends s. 409.974, F.S., to require the DOH's CMS program to do all of the following:

- Effective July 1, 2025, transfer to the AHCA the operation of managed care contracts procured by the DOH for Medicaid and CHIP services provided to children and youth with special health care needs who are enrolled in the CMS Managed Care Plan.
- Conduct clinical eligibility screening for children and youth with special health care needs who are eligible for or are enrolled in Medicaid or CHIP.
- Provide ongoing consultation to the AHCA to ensure high-quality, family-centered, coordinated health services are provided within an effective system of care for children and youth with special health care needs.

The bill requires the AHCA to establish specific measures of access, quality, and costs of providing health care services to children and youth with special health care needs. The AHCA must contract with an independent evaluator to conduct an evaluation of the services provided. The evaluation must include, but need not be limited to, all of the following:

- A performance comparison of plans contracted to provide services to children and youth with special health care needs as well as plans contracted to serve a broader population of MMA enrollees. The performance comparison must be based on the measures established by the AHCA and differentiated based on the age and medical condition or diagnosis of patients receiving services under each plan.
- For each plan, an assessment of cost savings, patient choice, access to services, coordination of care, person-centered planning, health and quality-of-life outcomes, patient and provider satisfaction, and provider networks and quality of care.

The bill requires the AHCA to submit the results of the evaluation to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15, 2028.

Section 3 amends s. 391.016, F.S., to expand the purpose of the CMS program to include youth and delete the requirement that the CMS program coordinate and maintain a consistent medical home for participating children.

Section 4 amends s. 391.021, F.S., to rename "Children's Medical Services Network" to "Children's Medical Services Managed Care Plan," and "Children with special health care

needs" to "Children and youth with special health care needs." The bill also expands the definition of "Eligible individual" to include youth.

Section 5 amends s. 391.025, F.S., to:

- Update the statutes to reflect current practices by officially expanding the scope of the CMS program to include the newborn, infant, and toddler hearing screening program established in s. 383.145, F.S.; the CMAT; the Medical Foster Care Program; the Title V Children and Youth with Special Health Care Needs program; the Safety Net Program; Child Protection Teams and sexual abuse treatment programs established under s. 39.303, F.S., and the State Child Abuse Death Review Committee and local child abuse death review committees established in s. 383.402, F.S.
- Incorporate a reference to clarify that the Early Steps Program, which is a component of the CMS program, is established in ss. 391.301-391.308, F.S.
- Clarify the CMS Managed Care Plan is a component of the CMS program through the end of June 30, 2025.

Section 6 amends s. 391.026, F.S., to:

- Update the statutes to reflect current practices by expanding the powers and duties of the DOH to include:
  - Sponsoring or promoting grants for projects, programs, education, or research in the field of youth with special health care needs.
  - Recruitment, training, assessment, and monitoring for the Medical Foster Care Program.
  - Monitoring access and facilitating admissions of eligible children and youth to the Medical Foster Care Program and designated medical foster care homes.
  - Coordinating with the DCF and the AHCA or their designees as it pertains to the Medical Foster Care Program.
- Clarify the DOH is responsible for the oversight and operation of the CMS Managed Care Plan, including the management of health care premiums, capitation payments, and funds from government and private entities, through the end of June 30, 2025.
- Delete the following powers, duties, and responsibilities of the DOH requiring that the department:
  - Establish reimbursement mechanisms for the CMS network.
  - Establish CMS network standards and credentialing requirements for health care providers and services.
  - Serve as a provider and principal case manager for children with special health care needs under Titles XIX and XXI of the SSA.
  - Establish and operate a grievance resolution process for participants and health care providers.
  - Maintain program integrity in the CMS program.
- Update the term "Children with Special Health Care Needs program" to "Children and Youth with Special Health Care Needs program."
- Delete the authorization allowing the DOH to maintain a minimum reserve for the CMS network.

Section 7 creates a non-statutory section of the Laws of Florida, repealing subsections 391.026(8)-(11), F.S., effective July 1, 2025 (*See* Related Issues below).

Section 8 creates a non-statutory section of the Laws of Florida, repealing s. 391.028, F.S., effective July 1, 2025, to delete the following:

- The requirement providing that the Director of CMS be a physician who has specialized training and experience in the provision of health care to children, serve as the deputy secretary and Deputy State Health Officer for CMS, and be appointed by the State Surgeon General.
- All required program activities under physician supervision on a statewide basis.
- The requirement that each CMS area office be directed by a physician who has specialized training and experience in the provision of health care to children and be appointed by the director from the active panel of CMS physician consultants.

Section 9 amends s. 391.029, F.S., to clarify that the high-risk pregnant females enrolled in Medicaid who are eligible to receive services through the CMS program are related to the regional perinatal intensive care centers. The bill updates the provisions related to eligibility for the CMS program, amending the language to conform with other technical changes, indicating that children and youth with serious special health care needs who are enrolled in Medicaid or CHIP will be eligible.

The bill also clarifies that children and youth with serious special health care needs who do not qualify for Medicaid or CHIP but who are unable to access services, as well as children and youth as provided in Title V of the Social Security Act, may receive services under the CMS Safety Net program. The bill deletes the requirement that the Florida Birth-Related Neurological Injury Compensation Association[59] reimburse the CMS Network the state's share of funding to obtain matching federal funds under CHIP.

Section 10 amends s. 391.0315, F.S., to require that benefits provided under the CMS Managed Care Plan be equivalent to Medicaid benefits mandated under ss. 409.905 and 409.906, F.S. The bill clarifies that the additional benefits the DOH is authorized to offer are through the components of the CMS program.

The bill repeals s. 391.0315, F.S., on January 1, 2026.

Section 11 repeals s. 391.035, F.S., relating to CMS provider qualifications.

[59] The state of Florida faced a medical malpractice crisis in the 1970s and 80s. During that time, obstetrics malpractice claims rose sharply and medical liability insurance skyrocketed. Therefore, in 1986, the Legislature created a special task force to study the Florida medical malpractice crisis and address the OB-GYN impact on that crisis. The task force evaluated the rising insurance costs and reported that litigation costs and attorney's fees had increased between 1975 and 1986, but there was no particular change in substantive law to account for the change. Moreover, some physicians became reluctant to treat high-risk patients and practice certain high-risk specialties altogether. In 1985, OB-GYNs in Florida paid an average medical malpractice liability premium of $185,460, compared to a national average for OB-GYNs of $23,300. In response, the Florida Legislature created the Florida Birth-Related Neurological Injury Compensation Association (NICA) in 1988 to promote and protect the health and best interests of children with birth-related neurological injuries who have been accepted into the plan by striving to ensure that their medically necessary needs are being met. NICA is a no-fault alternative to medical malpractice lawsuits for the kind of injuries that carry the highest cost and system impact. The program shifts those costly cases out of the tort system, which helped to stabilize Florida's medical malpractice insurance market and encouraged Florida's obstetricians to continue delivering babies. See NICA, *About NICA, available at* https://www.nica.com/about-nica/ (last visited Mar. 30, 2025).

Section 12 repeals s. 391.037, F.S., effective January 1, 2026, deleting provisions that clarify circumstances in which it is not a violation of s. 112.313(7), F.S., for a physician who is providing private sector services to clients of the DOH or who is employed by or has a contractual relationship with any business entity or agency that is a contract provider of the DOH to also be employed by the DOH to provide CMS services or services to assist in proceedings related to children.

Section 13 repeals s. 391.045, F.S., related to the reimbursement of CMS network health care providers by the DOH and reimbursement to the CMS program for applicable Florida Kidcare recipients.

Section 14 repeals s. 391.047, F.S., effective January 1, 2026, which requires the CMS program to comply with s. 402.24, F.S., concerning third-party liabilities and recovery of third-party payments for health services.

Section 15 repeals s. 391.055, F.S., effective January 1, 2026, related to service delivery systems of the CMS network.

Section 16 repeals s. 391.071, F.S., effective January 1, 2026, related to quality-of-care requirements for health care providers participating in the CMS program.

Section 17 amends s. 391.097, F.S., to delete the requirement that the CMS network be included in any evaluation conducted in accordance with the provisions of CHIP as enacted by the Legislature.

Section 18 creates an undesignated section of the Laws of Florida, repealing ss. 391.221 and 391.223, F.S., eliminating the Statewide CMS Network Advisory Council and CMS program technical advisory panels.

Section 19 amends s. 409.166, F.S., to substitute CMS network services provided under the purview of the DOH for services through a plan under contract with the AHCA to serve children and youth with special health care needs effective July 1, 2025.

Section 20 amends s. 409.811, F.S., to delete the definition of "Children's Medical Services Network" or "network" effective July 1, 2025, as it applies to the Florida Kidcare Act.

Section 21 amends s. 409.813, F.S., to replace the CMS network established under ch. 391, F.S., with plans under contract with the AHCA to serve children and youth with special health care needs as a program component of the Florida Kidcare program effective July 1, 2025.

Sections 22, 24, and 25 amend ss. 409.8134, 409.815, and 409.8177, F.S., to replace the term "Children's Medical Services Network" with "a plan under contract with the AHCA to serve children with special health care needs" effective July 1, 2025.

Section 23 amends s. 409.814, F.S., to replace the term "Children's Medical Services Network" with "a plan under contract with the AHCA to serve children with special health care needs," and "clinical screening" with "CMS clinical screening."

Section 26 amends s. 409.818, F.S., to delete the CMS Network from the entities excluded from certification[60] by the Florida Office of Insurance Regulation (OIR)[61] effective July 1, 2025.

Section 27 amends s. 409.912, F.S., to delete the reference to the CMS network as it pertains to the program of all-inclusive care for children (PACC)[62] effective July 1, 2025.

Section 28 amends s. 409.9126, F.S., to clarify that children eligible for the CMS program receiving Medicaid benefits, and other Medicaid-eligible children with special health care needs, are exempt from s. 409.9122, F.S., effective July 1, 2025. The bill also removes the provision that these children would be served through the CMS network established in ch. 391, F.S.

Section 29 amends s. 409.9131, F.S., to delete the requirement that the AHCA consider whether individual patients are clients of the CMS Network established in ch. 391, F.S., when considering the patient case mix of a physician for the determination of overpayment, effective July 1, 2025.

Section 30 amends s. 409.920, F.S., to delete the CMS Network authorized under ch. 391, F.S., from the definition of a managed care plan, effective July 1, 2025.

Section 31 amends s. 409.962, F.S., to delete the CMS Network authorized under ch. 391, F.S., from the definition of an eligible plan, effective July 1, 2025.

Section 32 creates a non-statutory section of the Laws of Florida to require the AHCA to develop a comprehensive plan to redesign the Florida Medicaid Model Waiver for home and community-based services to include children who receive PDN services. The plan must propose an array of tiered services with the goal of ensuring that institutional care is avoided so children can remain in the home or other community setting. The AHCA must work with stakeholders in developing the plan, including, but not limited to, families of children who are in the model waiver or receiving PDN, advocates for children, providers of services to children receiving PDN, and SMMC plans. The AHCA is authorized to contract with necessary experts to assist in

[60] The Company Admission units of the OIR work closely with companies to submit applications for a Certificate of Authority to transact insurance in this state and facilitate the application process. *See* Office of Insurance Regulation, *Organization and Operation, available at* https://floir.com/about-us/organization-and-operation (last visited Mar. 30, 2025).
[61] The OIR is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Florida Insurance Code or ch. 636, F.S. *See* Office of Insurance Regulation, *Organization and Operation, available at* https://floir.com/about-us/organization-and-operation (last visited Mar. 30, 2025).
[62] PACC is a palliative care model providing pediatric palliative care to enrollees of the CMS Managed Care Plan who have special health care needs and a potentially life-threatening condition. Services are provided from the time of diagnosis throughout the treatment phase of illness, including end-of-life care, to reduce hospitalizations. See Florida Department of Health, *Florida's Program for All Inclusive Care for Children, PARTNERS IN CARE: TOGETHER FOR KIDS, PROGRAM GUIDELINES* (Nov. 2021), *available at* https://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/partners-in-care/_documents/PICTFKProgramGuidelines.pdf (last visited Mar. 30, 2025).

developing the plan. The AHCA must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by September 30, 2025, addressing, at a minimum, all of the following:

- The purpose, rationale, and expected benefits of the redesigned waiver plan.
- The proposed eligibility criteria for clients and service benefit packages to be offered through the redesigned waiver plan. Managed care plans participating in the SMMC program must provide services under the redesigned waiver plan.
- A proposed implementation plan and timeline, including, but not limited to, recommendations for the number of clients served by the redesigned waiver plan at initial implementation, changes over time, and any per-client benefit caps.
- The fiscal impact for the implementation year and projections for the next five years determined on an actuarially sound basis.
- An analysis of the availability of services and service providers that would be offered under the redesigned waiver plan and recommendations to increase the availability of such services, as applicable.
- A list of all stakeholders, public and private, who were consulted or contacted during the development of the plan.

Section 33 provides that the bill takes effect upon becoming law, except as otherwise expressly provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Section 6 of Article III, of the State Constitution, requires that every law embrace but one subject and matter properly connected therewith, and the subject must be briefly expressed in the title. As written, the title, Children's Medical Services program, does not reflect all content of the bill relating to the Florida Medicaid Model waiver.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The transfer of staff from the DOH's Division of CMS to the AHCA is budget neutral.

VI. Technical Deficiencies:

Under s. 409.166(4)(f), F.S., the DCF may provide adoption assistance to adoptive parents for medical assistance initiated after the adoption of a child for medical, surgical, hospital, and related services needed as a result of the physical or mental condition of the child which existed before the adoption and is not covered by Medicaid, CMS, or Children's Mental Health Services. As the bill is written, it is unclear whether CMS references the program, the Managed Care Plan, or both.

The bill amends s. 409.814(10)(c), F.S., to clarify that the term "clinical screening" is referencing a CMS clinical screening. It may be beneficial to indicate the clinical screening is one conducted by the CMS program for further clarity.

VII. Related Issues:

The following deletions may result in CMS program operational issues and confusion:

- Section 6 of the bill deletes the requirement that the DOH maintain program integrity in the CMS program.
- Section 7 repeals subsections 391.026(8)-(11), F.S. This deletes the powers, duties, and responsibilities required of the DOH related to the CMS Managed Care Plan; however, it also deletes the following duties of the department to:
  - Monitor the provision of health services in the CMS program, including the utilization and quality of health services.
  - Administer the Children and Youth with Special Health Care Needs program in accordance with Title V of the SSA.
- Section 12 deletes provisions that clarify instances in which it is not a violation of s. 112.313(7), F.S., for a physician who is involved with the DOH under certain circumstances to also be employed by the DOH to provide CMS services or services to assist in proceedings related to children.
- Section 14 repeals the requirement that the CMS program comply with s. 402.24, F.S., concerning third-party liabilities and recovery of third-party payments for health services.
- Section 16 repeals provisions related to quality-of-care requirements for health care providers participating in the CMS program.

VIII. Statutes Affected:

The bill creates undesignated sections of the Laws of Florida.

This bill substantially amends the following sections of the Florida Statutes: 391.016, 391.021, 391.025, 391.026, 391.029, 391.0315, 391.097, 409.166, 409.811, 409.813, 409.8134, 409.814, 409.815, 409.8177, 409.818, 409.912, 409.9126, 409.9131, 409.920, 409.962, and 409.974.

This bill repeals the following sections of the Florida Statutes: 391.026(8), 391.026(9), 3291.026(10), 391.026(11), 391.028, 391.035, 391.037, 391.045, 391.047, 391.055, 391.071, 391.221, and 391.223.

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:
The committee substitute:

- Deletes the underlying bill's provisions shifting Florida Medicaid's prescribed pediatric extended care (PPEC) services from a fee-for-service delivery model to managed care.
- Removes the underlying bill's requirement that the AHCA seek federal approval to revise Florida's Medicaid Model Waiver, instead requiring the AHCA to develop a comprehensive plan to redesign the Medicaid Model Waiver and submit a report to the Governor and the Legislature by September 30, 2025.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/02/2025	.	
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	.	
	.	

The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with title amendment)

Delete lines 102 - 691

and insert:

Section 2. Subsection (4) of section 409.974, Florida Statutes, is amended to read:

409.974 Eligible plans.—

(4) CHILDREN'S MEDICAL SERVICES ~~NETWORK~~.—

(a) The Department of Health's Children's Medical Services program shall do all of the following:

865162

1. Effective July 1, 2025, transfer to the agency the operation of managed care contracts procured by the department for Medicaid and Children's Health Insurance Program services provided to children and youth with special health care needs who are enrolled in the Children's Medical Services Managed Care Plan.

2. Conduct clinical eligibility screening for children and youth with special health care needs who are eligible for or are enrolled in Medicaid or the Children's Health Insurance Program.

3. Provide ongoing consultation to the agency to ensure high-quality, family-centered, coordinated health services are provided within an effective system of care for children and youth with special health care needs.

(b) The agency shall establish specific measures of access, quality, and costs of providing health care services to children and youth with special health care needs. The agency shall contract with an independent evaluator to conduct an evaluation of services provided. The evaluation must include, but need not be limited to, all of the following:

1. A performance comparison of plans contracted to provide services to children and youth with special health care needs as well as plans contracted to serve a broader population of Managed Medical Assistance enrollees. The performance comparison must be based on the measures established by the agency and differentiated based on the age and medical condition or diagnosis of patients receiving services under each plan.

2. For each plan, an assessment of cost savings, patient choice, access to services, coordination of care, person-centered planning, health and quality-of-life outcomes, patient



and provider satisfaction, and provider networks and quality of care.

The agency shall submit the results of the evaluation to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15, 2028 ~~Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency that is not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program~~.

Section 3. Subsection (1) of section 391.016, Florida Statutes, is amended to read:

391.016 Purposes and functions.—The Children's Medical Services program is established for the following purposes and authorized to perform the following functions:

(1) Provide to children and youth with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric specialty care. ~~The program shall coordinate and maintain a consistent medical home for participating children.~~

Section 4. Subsections (1), (2), and (4) of section 391.021, Florida Statutes, are reordered and amended to read:

391.021 Definitions.—When used in this act, the term:

(2)~~(1)~~ "Children's Medical Services Managed Care Plan ~~network~~" or "plan ~~network~~" means a statewide managed care service system that includes health care providers, as defined



in this section.

(1) ~~(2)~~ "Children and youth with special health care needs" means those children and youth younger than 21 years of age who have chronic and serious physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children and youth.

(4) "Eligible individual" means a child or youth with a special health care need or a female with a high-risk pregnancy, who meets the financial and medical eligibility standards established in s. 391.029.

Section 5. Subsection (1) of section 391.025, Florida Statutes, is amended to read:

391.025 Applicability and scope.—

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

(a) The newborn screening program established in s. 383.14 and the newborn, infant, and toddler hearing screening program established in s. 383.145.

(b) The regional perinatal intensive care centers program established in ss. 383.15-383.19.

(c) The developmental evaluation and intervention program, including the Early Steps Program established in ss. 391.301-391.308.

(d) The Children's Medical Services Managed Care Plan through the end of June 30, 2025 ~~network~~.

(e) The Children's Multidisciplinary Assessment Team.

(f) The Medical Foster Care Program.

(g) The Title V Children and Youth with Special Health Care

865162

Needs program.

(h) The Safety Net Program.

(i) Child Protection Teams and sexual abuse treatment programs established under s. 39.303.

(j) The State Child Abuse Death Review Committee and local child abuse death review committees established in s. 383.402.

Section 6. Section 391.026, Florida Statutes, is amended to read:

391.026 Powers and duties of the department.—The department shall have the following powers, duties, and responsibilities:

(1) To provide or contract for the provision of health services to eligible individuals.

(2) To provide services to abused and neglected children through Child Protection Teams pursuant to s. 39.303.

(3) To determine the medical and financial eligibility of individuals seeking health services from the program.

(4) To coordinate a comprehensive delivery system for eligible individuals to take maximum advantage of all available funds.

(5) To coordinate with programs relating to children's medical services in cooperation with other public and private agencies.

(6) To initiate and coordinate applications to federal agencies and private organizations for funds, services, or commodities relating to children's medical programs.

(7) To sponsor or promote grants for projects, programs, education, or research in the field of children and youth with special health care needs, with an emphasis on early diagnosis and treatment.


865162

(8) To oversee and operate the Children's Medical Services Managed Care Plan through the end of June 30, 2025 ~~network~~.

(9) ~~To establish reimbursement mechanisms for the Children's Medical Services network.~~

~~(10) To establish Children's Medical Services network standards and credentialing requirements for health care providers and health care services.~~

~~(11) To serve as a provider and principal case manager for children with special health care needs under Titles XIX and XXI of the Social Security Act.~~

~~(12)~~ To monitor the provision of health services in the program, including the utilization and quality of health services.

(10)~~(13)~~ To administer the Children and Youth with Special Health Care Needs program in accordance with Title V of the Social Security Act.

~~(14) To establish and operate a grievance resolution process for participants and health care providers.~~

~~(15) To maintain program integrity in the Children's Medical Services program.~~

(11)~~(16)~~ To receive and manage health care premiums, capitation payments, and funds from federal, state, local, and private entities for the program. The department may contract with a third-party administrator for processing claims, monitoring medical expenses, and other related services necessary to the efficient and cost-effective operation of the Children's Medical Services Managed Care Plan through the end of June 30, 2025 ~~network. The department is authorized to maintain a minimum reserve for the Children's Medical Services network in~~

865162

~~an amount that is the greater of:~~

~~(a) Ten percent of total projected expenditures for Title XIX-funded and Title XXI-funded children; or~~

~~(b) Two percent of total annualized payments from the Agency for Health Care Administration for Title XIX and Title XXI of the Social Security Act~~.

(12)~~(17)~~ To provide or contract for peer review and other quality-improvement activities.

(13)~~(18)~~ To adopt rules pursuant to ss. 120.536(1) and 120.54 to administer the Children's Medical Services Act.

(14)~~(19)~~ To serve as the lead agency in administering the Early Steps Program pursuant to part C of the federal Individuals with Disabilities Education Act and part III of this chapter.

(15) To administer the Medical Foster Care Program, including all of the following:

(a) Recruitment, training, assessment, and monitoring for the Medical Foster Care Program.

(b) Monitoring access and facilitating admissions of eligible children and youth to the program and designated medical foster care homes.

(c) Coordination with the Department of Children and Families and the Agency for Health Care Administration or their designees.

Section 7. Effective July 1, 2025, subsections (8) through (11) of section 391.026, Florida Statutes, as amended by this act, are repealed.

Section 8. Effective July 1, 2025, section 391.028, Florida Statutes, is repealed.

865162

Section 9. Subsections (2) and (3) of section 391.029, Florida Statutes, are amended to read:

391.029 Program eligibility.—

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

(a) Related to the regional perinatal intensive care centers, a high-risk pregnant female who is enrolled in Medicaid.

(b) Children and youth with serious special health care needs from birth to 21 years of age who are enrolled in Medicaid.

(c) Children and youth with serious special health care needs from birth to 19 years of age who are enrolled in a program under Title XXI of the Social Security Act.

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

(a) Children and youth with serious special health care needs from birth to 21 years of age who do not qualify for Medicaid or Title XXI of the Social Security Act but who are unable to access, due to lack of providers or lack of financial resources, specialized services that are medically necessary or essential family support services. Families shall participate financially in the cost of care based on a sliding fee scale established by the department.

(b) Children and youth with special health care needs from birth to 21 years of age, as provided in Title V of the Social Security Act.

(c) An infant who receives an award of compensation under

865162

s. 766.31(1). ~~The Florida Birth-Related Neurological Injury Compensation Association shall reimburse the Children's Medical Services Network the state's share of funding, which must thereafter be used to obtain matching federal funds under Title XXI of the Social Security Act.~~

Section 10. Section 391.0315, Florida Statutes, is amended to read:

391.0315 Benefits.—Benefits provided under the Children's Medical Services Managed Care Plan ~~program for children with special health care needs~~ shall be equivalent to benefits provided to children as specified in ss. 409.905 and 409.906. The department may offer additional benefits through Children's Medical Services programs for early intervention services, respite services, genetic testing, genetic and nutritional counseling, and parent support services, if such services are determined to be medically necessary. This section is repealed on January 1, 2026.

Section 11. Section 391.035, Florida Statutes, is repealed.

Section 12. Effective January 1, 2026, section 391.037, Florida Statutes, is repealed.

Section 13. Section 391.045, Florida Statutes, is repealed.

Section 14. Effective January 1, 2026, section 391.047, Florida Statutes, is repealed.

Section 15. Effective January 1, 2026, section 391.055, Florida Statutes, is repealed.

Section 16. Effective January 1, 2026, section 391.071, Florida Statutes, is repealed.

Section 17. Section 391.097, Florida Statutes, is amended to read:


865162

391.097 Research and evaluation.—

~~(1)~~ The department may initiate, fund, and conduct research and evaluation projects to improve the delivery of children's medical services. The department may cooperate with public and private agencies engaged in work of a similar nature.

~~(2) The Children's Medical Services network shall be included in any evaluation conducted in accordance with the provisions of Title XXI of the Social Security Act as enacted by the Legislature.~~

Section 18. Part II of chapter 391, Florida Statutes, consisting of ss. 391.221 and 391.223, Florida Statutes, is repealed, and part III of that chapter is redesignated as part II.

Section 19. Effective July 1, 2025, paragraph (b) of subsection (5) of section 409.166, Florida Statutes, is amended to read:

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

(5) ELIGIBILITY FOR SERVICES.—

(b) A child who is handicapped at the time of adoption is ~~shall be~~ eligible for services through a plan under contract with the agency to serve children and youth with special heath care needs ~~the Children's Medical Services network established under part I of chapter 391~~ if the child was eligible for such services before ~~prior to~~ the adoption.

Section 20. Effective July 1, 2025, subsection (7) of section 409.811, Florida Statutes, is amended to read:

409.811 Definitions relating to Florida Kidcare Act.—As used in ss. 409.810-409.821, the term:


865162

~~(7) "Children's Medical Services Network" or "network" means a statewide managed care service system as defined in s. 391.021(1).~~

Section 21. Effective July 1, 2025, subsection (1) of section 409.813, Florida Statutes, is amended to read:

409.813 Health benefits coverage; program components; entitlement and nonentitlement.—

(1) The Florida Kidcare program includes health benefits coverage provided to children through the following program components, which shall be marketed as the Florida Kidcare program:

(a) Medicaid;

(b) Medikids as created in s. 409.8132;

(c) The Florida Healthy Kids Corporation as created in s. 624.91;

(d) Employer-sponsored group health insurance plans approved under ss. 409.810-409.821; and

(e) Plans under contract with the agency to serve children and youth with special health care needs ~~The Children's Medical Services network established in chapter 391~~.

Section 22. Effective July 1, 2025, subsection (3) of section 409.8134, Florida Statutes, is amended to read:

409.8134 Program expenditure ceiling; enrollment.—

(3) Upon determination by the Social Services Estimating Conference that there are insufficient funds to finance the current enrollment in the Florida Kidcare program within current appropriations, the program shall initiate disenrollment procedures to remove enrollees, except those children enrolled in a plan under contract with the agency to serve children with

865162

special health care needs ~~the Children's Medical Services Network~~, on a last-in, first-out basis until the expenditure and appropriation levels are balanced.

Section 23. Subsection (3) and paragraph (c) of subsection (10) of section 409.814, Florida Statutes, are amended to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 300 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component.

(3) A Title XXI-funded child who is eligible for the Florida Kidcare program who is a child with special health care needs, as determined through a medical or behavioral screening instrument, is eligible for health benefits coverage from and shall be assigned to and may opt out of a plan under contract with the agency to serve children with special health care needs ~~the Children's Medical Services Network~~.

(10) In determining the eligibility of a child, an assets test is not required. If eligibility for the Florida Kidcare program cannot be verified using reliable data sources in accordance with federal requirements, each applicant shall provide documentation during the application process and the redetermination process, including, but not limited to, the following:

(c) To enroll in a plan under contract with the agency to service children with special health care needs ~~the Children's Medical Services Network~~, a completed application, including a



Children's Medical Services clinical screening.

Section 24. Effective July 1, 2025, paragraph (t) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(t) *Enhancements to minimum requirements.*—

1. This section sets the minimum benefits that must be included in any health benefits coverage, other than Medicaid or Medikids coverage, offered under ss. 409.810-409.821. Health benefits coverage may include additional benefits not included under this subsection, but may not include benefits excluded under paragraph (r).

2. Health benefits coverage may extend any limitations beyond the minimum benefits described in this section.

Except for a plan under contract with the agency to serve children with special health care needs ~~the Children's Medical Services Network~~, the agency may not increase the premium assistance payment for either additional benefits provided beyond the minimum benefits described in this section or the imposition of less restrictive service limitations.

Section 25. Effective July 1, 2025, paragraph (i) of subsection (1) of section 409.8177, Florida Statutes, is amended to read:



409.8177 Program evaluation.—

(1) The agency, in consultation with the Department of Health, the Department of Children and Families, and the Florida Healthy Kids Corporation, shall contract for an evaluation of the Florida Kidcare program and shall by January 1 of each year submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of the program. In addition to the items specified under s. 2108 of Title XXI of the Social Security Act, the report shall include an assessment of crowd-out and access to health care, as well as the following:

(i) An assessment of the effectiveness of the Florida Kidcare program, including Medicaid, the Florida Healthy Kids program, Medikids, and the plans under contract with the agency to serve children with special health care needs ~~Children's Medical Services network~~, and other public and private programs in the state in increasing the availability of affordable quality health insurance and health care for children.

Section 26. Effective July 1, 2025, subsection (4) of section 409.818, Florida Statutes, is amended to read:

409.818 Administration.—In order to implement ss. 409.810-409.821, the following agencies shall have the following duties:

(4) The Office of Insurance Regulation shall certify that health benefits coverage plans that seek to provide services under the Florida Kidcare program, except those offered through the Florida Healthy Kids Corporation ~~or the Children's Medical Services Network~~, meet, exceed, or are actuarially equivalent to the benchmark benefit plan and that health insurance plans will be offered at an approved rate. In determining actuarial

865162

equivalence of benefits coverage, the Office of Insurance Regulation and health insurance plans must comply with the requirements of s. 2103 of Title XXI of the Social Security Act. The department shall adopt rules necessary for certifying health benefits coverage plans.

Section 27. Effective July 1, 2025, subsection (11) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician’s opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify

865162

trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer

865162

review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(11) The agency shall implement a program of all-inclusive care for children. The program of all-inclusive care for children shall be established to provide in-home hospice-like support services to children diagnosed with a life-threatening illness ~~and enrolled in the Children's Medical Services network~~ to reduce hospitalizations as appropriate. The agency, in consultation with the Department of Health, may implement the program of all-inclusive care for children after obtaining approval from the Centers for Medicare and Medicaid Services.

Section 28. Effective July 1, 2025, subsection (1) of section 409.9126, Florida Statutes, is amended to read:

409.9126 Children with special health care needs.—

(1) Except as provided in subsection (4), children eligible for the Children's Medical Services program who receive Medicaid benefits, and other Medicaid-eligible children with special health care needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.9122 ~~and shall be served through the Children's Medical Services network established in chapter 391~~.

865162

Section 29. Effective July 1, 2025, paragraph (a) of subsection (5) of section 409.9131, Florida Statutes, is amended to read:

409.9131 Special provisions relating to integrity of the Medicaid program.—

(5) DETERMINATIONS OF OVERPAYMENT.—In making a determination of overpayment to a physician, the agency must:

(a) Use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, other generally accepted statistical methods, review of medical records, and a consideration of the physician's client case mix. Before performing a review of the physician's Medicaid records, however, the agency shall make every effort to consider the physician's patient case mix, including, but not limited to, patient age ~~and whether individual patients are clients of the Children's Medical Services Network established in chapter 391~~. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods and its other audit findings as evidence of overpayment.

Section 30. Effective July 1, 2025, paragraph (e) of subsection (1) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(1) For the purposes of this section, the term:

(e) "Managed care plans" means a health insurer authorized



under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641~~, the Children's Medical Services Network authorized under chapter 391~~, a prepaid health plan authorized under this chapter, a provider service network authorized under this chapter, a minority physician network authorized under this chapter, and an emergency department diversion program authorized under this chapter or the General Appropriations Act, providing health care services pursuant to a contract with the Medicaid program.

Section 31. Effective July 1, 2025, subsection (7) of section 409.962, Florida Statutes, is amended to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(7) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(1) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes ~~the Children's Medical Services Network authorized under chapter 391 and~~ entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

Section 32. The Agency for Health Care Administration shall

865162

develop a comprehensive plan to redesign the Florida Medicaid Model Waiver for home- and community-based services to include children who receive private duty nursing services. The plan must propose an array of tiered services with the goal of ensuring that institutional care is avoided so children can remain in the home or other community setting. The agency shall work with stakeholders in developing the plan, including, but not limited to, families of children who are in the model waiver or receiving private duty nursing, advocates for children, providers of services to children receiving private duty nursing, and Statewide Medicaid Managed Care plans. The agency is authorized to contract with necessary experts to assist in developing the plan. The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by September 30, 2025, addressing, at a minimum, all of the following:

(1) The purpose, rationale, and expected benefits of the redesigned waiver plan.

(2) The proposed eligibility criteria for clients and service benefit packages to be offered through the redesigned waiver plan. Managed care plans participating in the Statewide Medicaid Managed Care program must provide services under the redesigned waiver plan.

(3) A proposed implementation plan and timeline, including, but not limited to, recommendations for the number of clients served by the redesigned waiver plan at initial implementation, changes over time, and any per-client benefit caps.

(4) The fiscal impact for the implementation year and projections for the next 5 years determined on an actuarially



865162

sound basis.

(5) An analysis of the availability of services and service providers that would be offered under the redesigned waiver plan and recommendations to increase availability of such services, as applicable.

(6) A list of all stakeholders, public and private, who were consulted or contacted during the development of the plan.

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

And the title is amended as follows:

Delete lines 15 - 68

and insert:

specified purpose; amending s. 409.974, F.S.; requiring the CMS program to transfer operation of certain managed care contracts from the department to the agency effective on a specified date; requiring the CMS program to conduct clinical eligibility screening for certain children and youth with special health care needs; requiring the program to provide ongoing consultation to the agency for a specified purpose; requiring the agency to establish specific measures for evaluation of services provided to children and youth with special health care needs; requiring the agency to contract with an independent evaluator to conduct the evaluation of services provided; specifying requirements for the evaluation; requiring the agency to submit the results of the evaluation to the Governor and the Legislature by a specified date; amending s. 391.016, F.S.; revising

865162

the purposes and functions of the CMS program; amending s. 391.021, F.S.; revising definitions; amending s. 391.025, F.S.; revising the scope of the CMS program; amending s. 391.026, F.S.; revising the powers and duties of the department to conform to changes made by the act; providing for the future repeal of s. 391.026(8) through (11), F.S., relating to the department's oversight and administration of the CMS program; repealing s. 391.028, F.S., relating to administration of the program; amending s. 391.029, F.S.; revising program eligibility requirements; conforming provisions to changes made by the act; amending s. 391.0315, F.S.; conforming provisions to changes made by the act; providing for future repeal of specified provisions; repealing ss. 391.035, 391.037, 391.045, 391.047, 391.055, and 391.071, F.S., relating to provider qualifications, physicians and private sector services, provider reimbursements, third-party payments, service delivery systems under the program, and quality of care requirements, respectively; amending s. 391.097, F.S.; conforming a provision to changes made by the act; repealing part II of ch. 391, F.S., consisting of ss. 391.221 and 391.223, F.S., relating to Children's Medical Services councils and panels; amending ss. 409.166, 409.811, 409.813, 409.8134, 409.814, 409.815, 409.8177, 409.818, 409.912, 409.9126, 409.9131, 409.920, and 409.962, F.S.; conforming provisions to changes made by the act; requiring the agency to develop a


865162

comprehensive plan to redesign the Florida Medicaid Model Waiver for home and community-based services to include children who receive private duty nursing services; providing requirements for the redesign of the waiver plan; requiring the agency to submit a report to the Governor and the Legislature by a specified date; providing requirements for the report; providing

By Senator Harrell

31-00791A-25 20251490__

A bill to be entitled

An act relating to the Children's Medical Services program; transferring operation of the Children's Medical Services Managed Care Plan from the Department of Health to the Agency for Health Care Administration, effective on a specified date; providing construction as to judicial and administrative actions pending as of a specified date and time; requiring the department's Children's Medical Services (CMS) program to collaborate with the agency in the care of children and youth with special health care needs; requiring the CMS program to conduct certain clinical eligibility screenings and provide ongoing consultation to the agency for a specified purpose; amending s. 409.906, F.S.; conforming a cross-reference; requiring the agency to seek federal approval to amend the state's Medicaid Model Waiver for home and community-based services to include certain services; requiring the agency to implement the approved waiver amendment subject to certain conditions; authorizing the agency to adopt rules; amending s. 409.974, F.S.; requiring the CMS program to transfer operation of certain managed care contracts from the department to the agency effective on a specified date; requiring the CMS program to conduct clinical eligibility screening for certain children and youth with special health care needs; requiring the program to provide ongoing consultation to the agency for a specified purpose; requiring the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

agency to establish specific measures for evaluation of services provided to children and youth with special health care needs; requiring the agency to contract with an independent evaluator to conduct the evaluation of services provided; specifying requirements for the evaluation; requiring the agency to submit the results of the evaluation to the Governor and the Legislature by a specified date; amending s. 391.016, F.S.; revising the purposes and functions of the CMS program; amending s. 391.021, F.S.; revising definitions; amending s. 391.025, F.S.; revising the scope of the CMS program; amending s. 391.026, F.S.; revising the powers and duties of the department to conform to changes made by the act; providing for the future repeal of s. 391.026(8) through (11), F.S., relating to the department's oversight and administration of the CMS program; repealing s. 391.028, F.S., relating to administration of the program; amending s. 391.029, F.S.; revising program eligibility requirements; conforming provisions to changes made by the act; amending s. 391.0315, F.S.; conforming provisions to changes made by the act; providing for future repeal of specified provisions; repealing ss. 391.035, 391.037, 391.045, 391.047, 391.055, and 391.071, F.S., relating to provider qualifications; physicians and private sector services; provider reimbursements; third-party payments; service delivery systems under the program; and quality of care requirements, respectively;

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

amending s. 391.097, F.S.; conforming a provision to changes made by the act; repealing part II of ch. 391, F.S., consisting of ss. 391.221 and 391.223, F.S., relating to the Statewide Children's Medical Services Network Advisory Council and technical advisory panels, respectively; amending ss. 409.166, 409.811, 409.813, 409.8134, 409.814, 409.815, 409.8177, 409.818, 409.912, 409.9126, 409.9131, 409.920, 409.962, 409.968, and 409.972, F.S.; conforming provisions to changes made by the act; providing effective dates.

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

Section 1. Transfer of operation of the Children's Medical Services Managed Care Plan.—

(1) Effective July 1, 2025, all statutory powers, duties, functions, records, personnel, pending issues, existing contracts, administrative authority, administrative rules, and unexpended balances of appropriations, allocations, and other funds for the operation of the Department of Health's Children's Medical Services Managed Care Plan are transferred to the Agency for Health Care Administration.

(2) The transfer of operations of the Children's Medical Services Managed Care Plan does not affect the validity of any judicial or administrative action pending as of 11:59 p.m. on the day before the effective date of the transfer to which the Department of Health's Children's Medical Services Managed Care Plan is at that time a party, and the Agency for Health Care

Administration shall be substituted as a party in interest in any such action.

(3) The Department of Health's Children's Medical Services program shall collaborate with the Agency for Health Care Administration in the care of children and youth with special health care needs. The Department of Health's Children's Medical Services program shall do all of the following:

(a) Conduct clinical eligibility screening for children and youth with special health care needs who are eligible for or enrolled in Medicaid or the Children's Health Insurance Program.

(b) Provide ongoing consultation to the Agency for Health Care Administration to ensure high-quality, family-centered, coordinated health services within an effective system of care for children and youth with special health care needs.

Section 2. Paragraph (d) of subsection (13) of section 409.906, Florida Statutes, is amended, and paragraph (e) is added to that subsection, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or

number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

(d) The agency shall seek federal approval to pay for flexible services for persons with severe mental illness or substance use disorders, including, but not limited to, temporary housing assistance. Payments may be made as enhanced capitation rates or incentive payments to managed care plans that meet the requirements of s. 409.968(3) ~~s. 409.968(4)~~.

(e) The agency shall seek federal approval to amend Florida's Medicaid Model Waiver for home and community-based services to include children who receive private duty nursing services. The amended waiver must provide an array of tiered services to more broadly serve medically fragile children who receive private duty nursing services and must ensure that institutional care is avoided so children can remain in the home or community setting. Services provided under the waiver must be provided by health plans participating in the Statewide Medicaid Managed Care program. The agency shall implement the approved waiver amendment subject to the availability of funds and any limitations provided in the General Appropriations Act,

including a limitation on the number of enrollees in the revised waiver. The agency may adopt rules to implement this paragraph.

Section 3. Subsection (4) of section 409.974, Florida Statutes, is amended to read:

409.974 Eligible plans.—

(4) CHILDREN'S MEDICAL SERVICES ~~NETWORK~~.—

(a) The Department of Health's Children's Medical Services program shall do all of the following:

1. Effective July 1, 2025, transfer to the agency the operation of managed care contracts procured by the department for Medicaid and Children's Health Insurance Program services provided to children and youth with special health care needs who are enrolled in the Children's Medical Services Managed Care Plan.

2. Conduct clinical eligibility screening for children and youth with special health care needs who are eligible for or are enrolled in Medicaid or the Children's Health Insurance Program.

3. Provide ongoing consultation to the agency to ensure high-quality, family-centered, coordinated health services are provided within an effective system of care for children and youth with special health care needs.

(b) The agency shall establish specific measures of access, quality, and costs of providing health care services to children and youth with special health care needs. The agency shall contract with an independent evaluator to conduct an evaluation of services provided. The evaluation must include, but need not be limited to, all of the following:

1. A performance comparison of plans contracted to provide services to children and youth with special health care needs as

well as plans contracted to serve a broader population of Managed Medical Assistance enrollees. The performance comparison must be based on the measures established by the agency and differentiated based on the age and medical condition or diagnosis of patients receiving services under each plan.

2. For each plan, an assessment of cost savings, patient choice, access to services, coordination of care, person-centered planning, health and quality-of-life outcomes, patient and provider satisfaction, and provider networks and quality of care.

The agency shall submit the results of the evaluation to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15, 2028 ~~Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency that is not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program~~.

Section 4. Subsection (1) of section 391.016, Florida Statutes, is amended to read:

391.016 Purposes and functions.—The Children's Medical Services program is established for the following purposes and authorized to perform the following functions:

(1) Provide to children and youth with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary

pediatric specialty care. ~~The program shall coordinate and maintain a consistent medical home for participating children.~~

Section 5. Subsections (1), (2), and (4) of section 391.021, Florida Statutes, are reordered and amended to read:

391.021 Definitions.—When used in this act, the term:

(2)~~(1)~~ "Children's Medical Services Managed Care Plan ~~network~~" or "plan ~~network~~" means a statewide managed care service system that includes health care providers, as defined in this section.

(1)~~(2)~~ "Children and youth with special health care needs" means those children and youth younger than 21 years of age who have chronic and serious physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children and youth.

(4) "Eligible individual" means a child or youth with a special health care need or a female with a high-risk pregnancy, who meets the financial and medical eligibility standards established in s. 391.029.

Section 6. Subsection (1) of section 391.025, Florida Statutes, is amended to read:

391.025 Applicability and scope.—

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

(a) The newborn screening program established in s. 383.14 and the newborn, infant, and toddler hearing screening program established in s. 383.145.

(b) The regional perinatal intensive care centers program established in ss. 383.15-383.19.

(c) The developmental evaluation and intervention program, including the Early Steps Program established in ss. 391.301-391.308.

(d) The Children's Medical Services Managed Care Plan through the end of June 30, 2025 ~~network~~.

(e) The Children's Multidisciplinary Assessment Team.

(f) The Medical Foster Care Program.

(g) The Title V Children and Youth with Special Health Care Needs program.

(h) The Safety Net Program.

(i) Child Protection Teams and sexual abuse treatment programs established under s. 39.303.

(j) The State Child Abuse Death Review Committee and local child abuse death review committees established in s. 383.402.

Section 7. Section 391.026, Florida Statutes, is amended to read:

391.026 Powers and duties of the department.—The department shall have the following powers, duties, and responsibilities:

(1) To provide or contract for the provision of health services to eligible individuals.

(2) To provide services to abused and neglected children through Child Protection Teams pursuant to s. 39.303.

(3) To determine the medical and financial eligibility of individuals seeking health services from the program.

(4) To coordinate a comprehensive delivery system for eligible individuals to take maximum advantage of all available funds.

(5) To coordinate with programs relating to children's medical services in cooperation with other public and private

agencies.

(6) To initiate and coordinate applications to federal agencies and private organizations for funds, services, or commodities relating to children's medical programs.

(7) To sponsor or promote grants for projects, programs, education, or research in the field of children and youth with special health care needs, with an emphasis on early diagnosis and treatment.

(8) To oversee and operate the Children's Medical Services Managed Care Plan through the end of June 30, 2025 ~~network~~.

(9) ~~To establish reimbursement mechanisms for the Children's Medical Services network.~~

~~(10) To establish Children's Medical Services network standards and credentialing requirements for health care providers and health care services.~~

~~(11) To serve as a provider and principal case manager for children with special health care needs under Titles XIX and XXI of the Social Security Act.~~

~~(12)~~ To monitor the provision of health services in the program, including the utilization and quality of health services.

(10)~~(13)~~ To administer the Children and Youth with Special Health Care Needs program in accordance with Title V of the Social Security Act.

~~(14) To establish and operate a grievance resolution process for participants and health care providers.~~

~~(15) To maintain program integrity in the Children's Medical Services program.~~

(11)~~(16)~~ To receive and manage health care premiums,

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

capitation payments, and funds from federal, state, local, and private entities for the program. The department may contract with a third-party administrator for processing claims, monitoring medical expenses, and other related services necessary to the efficient and cost-effective operation of the Children's Medical Services Managed Care Plan through the end of June 30, 2025 ~~network. The department is authorized to maintain a minimum reserve for the Children's Medical Services network in an amount that is the greater of:~~

~~(a) Ten percent of total projected expenditures for Title XIX-funded and Title XXI-funded children; or~~

~~(b) Two percent of total annualized payments from the Agency for Health Care Administration for Title XIX and Title XXI of the Social Security Act~~.

(12)~~(17)~~ To provide or contract for peer review and other quality-improvement activities.

(13)~~(18)~~ To adopt rules pursuant to ss. 120.536(1) and 120.54 to administer the Children's Medical Services Act.

(14)~~(19)~~ To serve as the lead agency in administering the Early Steps Program pursuant to part C of the federal Individuals with Disabilities Education Act and part III of this chapter.

(15) To administer the Medical Foster Care Program, including all of the following:

(a) Recruitment, training, assessment, and monitoring for the Medical Foster Care Program.

(b) Monitoring access and facilitating admissions of eligible children and youth to the program and designated medical foster care homes.

(c) Coordination with the Department of Children and Families and the Agency for Health Care Administration or their designees.

Section 8. Effective July, 1, 2025, subsections (8) through (11) of section 391.026, Florida Statutes, as amended by this act, are repealed.

Section 9. Effective July 1, 2025, section 391.028, Florida Statutes, is repealed.

Section 10. Subsections (2) and (3) of section 391.029, Florida Statutes, are amended to read:

391.029 Program eligibility.—

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

(a) Related to the regional perinatal intensive care centers, a high-risk pregnant female who is enrolled in Medicaid.

(b) Children and youth with serious special health care needs from birth to 21 years of age who are enrolled in Medicaid.

(c) Children and youth with serious special health care needs from birth to 19 years of age who are enrolled in a program under Title XXI of the Social Security Act.

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

(a) Children and youth with serious special health care needs from birth to 21 years of age who do not qualify for Medicaid or Title XXI of the Social Security Act but who are unable to access, due to lack of providers or lack of financial

resources, specialized services that are medically necessary or essential family support services. Families shall participate financially in the cost of care based on a sliding fee scale established by the department.

(b) Children and youth with special health care needs from birth to 21 years of age, as provided in Title V of the Social Security Act.

(c) An infant who receives an award of compensation under s. 766.31(1). ~~The Florida Birth-Related Neurological Injury Compensation Association shall reimburse the Children's Medical Services Network the state's share of funding, which must thereafter be used to obtain matching federal funds under Title XXI of the Social Security Act.~~

Section 11. Section 391.0315, Florida Statutes, is amended to read:

391.0315 Benefits.—Benefits provided under the Children's Medical Services Managed Care Plan ~~program for children with special health care needs~~ shall be equivalent to benefits provided to children as specified in ss. 409.905 and 409.906. The department may offer additional benefits through Children's Medical Services programs for early intervention services, respite services, genetic testing, genetic and nutritional counseling, and parent support services, if such services are determined to be medically necessary. This section is repealed on January 1, 2026.

Section 12. Section 391.035, Florida Statutes, is repealed.

Section 13. Effective January 1, 2026, section 391.037, Florida Statutes, is repealed.

Section 14. Section 391.045, Florida Statutes, is repealed.

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Section 15. Effective January 1, 2026, section 391.047, Florida Statutes, is repealed.

Section 16. Effective January 1, 2026, section 391.055, Florida Statutes, is repealed.

Section 17. Effective January 1, 2026, section 391.071, Florida Statutes, is repealed.

Section 18. Section 391.097, Florida Statutes, is amended to read:

391.097 Research and evaluation.—

~~(1)~~ The department may initiate, fund, and conduct research and evaluation projects to improve the delivery of children's medical services. The department may cooperate with public and private agencies engaged in work of a similar nature.

~~(2) The Children's Medical Services network shall be included in any evaluation conducted in accordance with the provisions of Title XXI of the Social Security Act as enacted by the Legislature.~~

Section 19. Part II of chapter 391, Florida Statutes, consisting of ss. 391.221 and 391.223, Florida Statutes, is repealed, and part III of that chapter is redesignated as part II.

Section 20. Effective July 1, 2025, paragraph (b) of subsection (5) of section 409.166, Florida Statutes, is amended to read:

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

(5) ELIGIBILITY FOR SERVICES.—

(b) A child who is handicapped at the time of adoption is ~~shall be~~ eligible for services through a plan under contract

with the agency to serve children and youth with special heath care needs ~~the Children's Medical Services network established under part I of chapter 391~~ if the child was eligible for such services before ~~prior to~~ the adoption.

Section 21. Effective July 1, 2025, subsection (7) of section 409.811, Florida Statutes, is amended to read:

409.811 Definitions relating to Florida Kidcare Act.—As used in ss. 409.810-409.821, the term:

~~(7) "Children's Medical Services Network" or "network" means a statewide managed care service system as defined in s. 391.021(1).~~

Section 22. Effective July 1, 2025, subsection (1) of section 409.813, Florida Statutes, is amended to read:

409.813 Health benefits coverage; program components; entitlement and nonentitlement.—

(1) The Florida Kidcare program includes health benefits coverage provided to children through the following program components, which shall be marketed as the Florida Kidcare program:

(a) Medicaid;

(b) Medikids as created in s. 409.8132;

(c) The Florida Healthy Kids Corporation as created in s. 624.91;

(d) Employer-sponsored group health insurance plans approved under ss. 409.810-409.821; and

(e) Plans under contract with the agency to serve children and youth with special health care needs ~~The Children's Medical Services network established in chapter 391~~.

Section 23. Effective July 1, 2025, subsection (3) of

section 409.8134, Florida Statutes, is amended to read:

409.8134 Program expenditure ceiling; enrollment.—

(3) Upon determination by the Social Services Estimating Conference that there are insufficient funds to finance the current enrollment in the Florida Kidcare program within current appropriations, the program shall initiate disenrollment procedures to remove enrollees, except those children enrolled in a plan under contract with the agency to serve children with special health care needs ~~the Children's Medical Services Network~~, on a last-in, first-out basis until the expenditure and appropriation levels are balanced.

Section 24. Subsection (3) and paragraph (c) of subsection (10) of section 409.814, Florida Statutes, are amended to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 300 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component.

(3) A Title XXI-funded child who is eligible for the Florida Kidcare program who is a child with special health care needs, as determined through a medical or behavioral screening instrument, is eligible for health benefits coverage from and shall be assigned to and may opt out of a plan under contract with the agency to serve children with special health care needs ~~the Children's Medical Services Network~~.

(10) In determining the eligibility of a child, an assets test is not required. If eligibility for the Florida Kidcare

program cannot be verified using reliable data sources in accordance with federal requirements, each applicant shall provide documentation during the application process and the redetermination process, including, but not limited to, the following:

(c) To enroll in a plan under contract with the agency to service children with special health care needs ~~the Children's Medical Services Network~~, a completed application, including a Children's Medical Services clinical screening.

Section 25. Effective July 1, 2025, paragraph (t) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(t) *Enhancements to minimum requirements.*—

1. This section sets the minimum benefits that must be included in any health benefits coverage, other than Medicaid or Medikids coverage, offered under ss. 409.810-409.821. Health benefits coverage may include additional benefits not included under this subsection, but may not include benefits excluded under paragraph (r).

2. Health benefits coverage may extend any limitations beyond the minimum benefits described in this section.

Except for a plan under contract with the agency to serve

children with special health care needs ~~the Children's Medical Services Network~~, the agency may not increase the premium assistance payment for either additional benefits provided beyond the minimum benefits described in this section or the imposition of less restrictive service limitations.

Section 26. Effective July 1, 2025, paragraph (i) of subsection (1) of section 409.8177, Florida Statutes, is amended to read:

409.8177 Program evaluation.—

(1) The agency, in consultation with the Department of Health, the Department of Children and Families, and the Florida Healthy Kids Corporation, shall contract for an evaluation of the Florida Kidcare program and shall by January 1 of each year submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of the program. In addition to the items specified under s. 2108 of Title XXI of the Social Security Act, the report shall include an assessment of crowd-out and access to health care, as well as the following:

(i) An assessment of the effectiveness of the Florida Kidcare program, including Medicaid, the Florida Healthy Kids program, Medikids, and the plans under contract with the agency to serve children with special health care needs ~~Children's Medical Services network~~, and other public and private programs in the state in increasing the availability of affordable quality health insurance and health care for children.

Section 27. Effective July 1, 2025, subsection (4) of section 409.818, Florida Statutes, is amended to read:

409.818 Administration.—In order to implement ss. 409.810-

409.821, the following agencies shall have the following duties:

(4) The Office of Insurance Regulation shall certify that health benefits coverage plans that seek to provide services under the Florida Kidcare program, except those offered through the Florida Healthy Kids Corporation ~~or the Children's Medical Services Network~~, meet, exceed, or are actuarially equivalent to the benchmark benefit plan and that health insurance plans will be offered at an approved rate. In determining actuarial equivalence of benefits coverage, the Office of Insurance Regulation and health insurance plans must comply with the requirements of s. 2103 of Title XXI of the Social Security Act. The department shall adopt rules necessary for certifying health benefits coverage plans.

Section 28. Effective July 1, 2025, subsection (11) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies,

including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based

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on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(11) The agency shall implement a program of all-inclusive care for children. The program of all-inclusive care for children shall be established to provide in-home hospice-like support services to children diagnosed with a life-threatening illness ~~and enrolled in the Children's Medical Services network~~ to reduce hospitalizations as appropriate. The agency, in consultation with the Department of Health, may implement the program of all-inclusive care for children after obtaining approval from the Centers for Medicare and Medicaid Services.

Section 29. Effective July 1, 2025, subsection (1) of

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section 409.9126, Florida Statutes, is amended to read:

409.9126 Children with special health care needs.—

(1) Except as provided in subsection (4), children eligible for the Children's Medical Services program who receive Medicaid benefits, and other Medicaid-eligible children with special health care needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.9122 ~~and shall be served through the Children's Medical Services network established in chapter 391~~.

Section 30. Effective July 1, 2025, paragraph (a) of subsection (5) of section 409.9131, Florida Statutes, is amended to read:

409.9131 Special provisions relating to integrity of the Medicaid program.—

(5) DETERMINATIONS OF OVERPAYMENT.—In making a determination of overpayment to a physician, the agency must:

(a) Use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, other generally accepted statistical methods, review of medical records, and a consideration of the physician's client case mix. Before performing a review of the physician's Medicaid records, however, the agency shall make every effort to consider the physician's patient case mix, including, but not limited to, patient age ~~and whether individual patients are clients of the Children's Medical Services Network established in chapter 391~~. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such

statistical methods and its other audit findings as evidence of overpayment.

Section 31. Effective July 1, 2025, paragraph (e) of subsection (1) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(1) For the purposes of this section, the term:

(e) "Managed care plans" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641~~, the Children's Medical Services Network authorized under chapter 391~~, a prepaid health plan authorized under this chapter, a provider service network authorized under this chapter, a minority physician network authorized under this chapter, and an emergency department diversion program authorized under this chapter or the General Appropriations Act, providing health care services pursuant to a contract with the Medicaid program.

Section 32. Effective July 1, 2025, subsection (7) of section 409.962, Florida Statutes, is amended to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(7) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(1) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes ~~the Children's Medical Services~~

~~Network authorized under chapter 391 and~~ entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

Section 33. Subsection (3) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

~~(3) Reimbursement for prescribed pediatric extended care services provided to children enrolled in a managed care plan under s. 409.972(1)(g) shall be paid to the prescribed pediatric extended care services provider by the agency on a fee-for-service basis.~~

Section 34. Paragraph (g) of subsection (1) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

~~(g) Children receiving services in a prescribed pediatric extended care center.~~

Section 35. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

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THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Higher Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

SENATOR GAYLE HARRELL
31st District

March 12, 2025

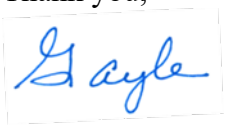
Senator Burton
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Burton,

I respectfully request that SB 1490 – Children's Medical Services Program be placed on the next available agenda for the Health Policy Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,



Senator Gayle Harrell
Senate District 31

Cc: Allen Brown, Staff Director
Anhar Al-Asadi, Committee Administrative Assistant

REPLY TO:
❒ 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
❒ 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

Tab 19

The Florida Senate

APPEARANCE RECORD

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

April 1, 2025
Meeting Date

Health Policy
Committee

SB 1490
Bill Number or Topic

Amendment Barcode (if applicable)

Name Brian Meyer, State Medicaid Director

Phone (888) 419-3456

Address 2727 Mahan Drive
Street

Email legaffairs@ahca.myflorida.com

Tallahassee FL 32308
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1182
INTRODUCER:	Senator Harrell
SUBJECT:	Medicaid Coverage of Continuous Glucose Monitors
DATE:	March 31, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Favorable**
2.			AHS	
3.			FP	

I. Summary:

SB 1182 creates undesignated sections of the Laws of Florida, to require the Florida Agency for Health Care Administration (AHCA) to seek federal approval as needed to provide coverage of continuous glucose monitors (CGMs) and related supplies as a durable medical equipment (DME) benefit for Medicaid recipients.

The bill provides requirements related to reimbursement and claims submission. The bill also does not prevent the AHCA from providing additional coverage of CGMs as a Medicaid pharmacy benefit.

The bill takes effect upon becoming law.

II. Present Situation:

What Is Diabetes?

Diabetes is a chronic health condition that affects how the human body turns food into energy.[1]

The human digestive system breaks down carbohydrates consumed as food into glucose[2] and releases it into the bloodstream, which increases the blood's glucose level. Such an increase in blood glucose should signal the pancreas[3] to release the hormone insulin, which acts as a catalyst

[1] U.S. Centers for Disease Control and Prevention, *Diabetes Basics, available at* https://www.cdc.gov/diabetes/about/?CDC_AAref_Val=https://www.cdc.gov/diabetes/basics/diabetes.html (last visited Mar. 28, 2025).

[2] Glucose is the simplest type of carbohydrate (chemical formula $C_6H_{12}O_6$), and all carbohydrates consumed as food must be broken down into glucose before the body can metabolize them.

[3] The pancreas is an organ located in the abdomen. It plays an essential role in converting food into fuel. The pancreas has two main functions: an exocrine function that helps in digestion and an endocrine function that regulates blood glucose. *See:* https://columbiasurgery.org/pancreas/pancreas-and-its-functions (last visited Mar. 15, 2025).

to allow the body's cells to metabolize the glucose and convert it to energy, or to convert the glucose into forms suitable for short-term or long-term storage.[4]

With diabetes, depending on the type of diabetes, the pancreas either does not make any insulin or does not make enough insulin, or the body cannot use insulin as well as it should. When there is not enough insulin or cells stop responding to insulin, blood glucose levels elevate and stay elevated for extended periods. Over time, that can cause serious health problems, such as heart disease, vision loss, kidney disease, vascular disease, and other maladies. Such outcomes are often known as long-term complications of diabetes.[5]

According to the American Diabetes Association, approximately 2.1 million adults in Florida, or 11.4 percent of the adult population, have diabetes.[6]

Types of Diabetes

There are three main types of diabetes: Type 1, Type 2, and gestational diabetes.[7]

Type 1 Diabetes

Type 1 diabetes is thought to be caused by an autoimmune reaction in which the body's immune system attacks and destroys the cells in the pancreas that normally produce insulin. Approximately five percent[8] of people with diabetes have Type 1. Symptoms of Type 1 often develop quickly. It is usually diagnosed in children, teens, and young adults (which has led the condition to sometimes be referred to as "juvenile diabetes"). An individual with Type 1 diabetes must take insulin, usually through subcutaneous injections, on a regular basis to survive, usually one or more times per day. Currently, Type 1 diabetes can neither be prevented nor cured.[9]

Type 2 Diabetes

With Type 2 diabetes, the body does not use insulin well and cannot keep blood glucose at normal levels.[10] About 90 to 95 percent of people with diabetes have Type 2. It develops over many years and is usually diagnosed in overweight, middle-aged adults; however, manifestations in children, teens, and young adults have increased annually in recent years. Type 2 diabetes can often be prevented or delayed, or even eliminated altogether, with healthy lifestyle changes, such

[4] U.S. Department of Health & Human Services, National Institutes of Health, National Library of Medicine, National Center for Biotechnology Information, *Physiology, Carbohydrates* (May 12, 2023), *available at* https://www.ncbi.nlm.nih.gov/books/NBK459280/#:~:text=As%20carbohydrates%20are%20consumed%2C%20the,liver%20to%20release%20stored%20glucose. (last visited Mar. 28, 2025).
[5] *Supra* note 1.
[6] American Diabetes Association, *The Burden of Diabetes in Florida*, *available at* https://diabetes.org/sites/default/files/2024-03/adv_2024_state_fact_florida.pdf (last visited Mar. 28, 2025).
[7] *Supra* note 1.
[8] American Diabetes Association, *Statistics About Diabetes*, *available at* https://diabetes.org/about-diabetes/statistics/about-diabetes (last visited Mar. 28, 2025).
[9] *Supra* note 1.
[10] *Id*.

as losing weight, eating healthy food, and exercising regularly. Type 2 diabetes is usually treated with oral medications but can require insulin injections in some cases.[11]

Gestational Diabetes

Gestational diabetes develops in pregnant women who have never had diabetes. In pregnant women with gestational diabetes, the baby could be at higher risk for health problems. Gestational diabetes usually goes away after the baby is born; however, it correlates to a higher risk for Type 2 diabetes later in life. A baby delivered by a woman with gestational diabetes is more likely to become obese as a child or teen and to develop Type 2 diabetes later in life.[12]

Managing Diabetes

In order for Type 1 or Type 2 diabetics to avoid long-term complications, or for a pregnant woman with gestational diabetes to mitigate the effects of that condition, blood glucose levels must be managed to stay as close to normal ranges as possible.

The expected values for normal fasting blood glucose concentration are between 70 and 100 milligrams of glucose per deciliter (mg/dL) of whole blood, although normal levels may vary.[13]

Testing blood glucose levels is key to managing diabetes. Years of elevated blood glucose levels (hyperglycemia) can lead to diabetes' costly and disabling long-term complications, while levels that are too low (hypoglycemia) can be dangerous in an immediate sense and, in severe episodes, can lead to disorientation, unconsciousness, seizure, brain damage, or death.[14]

Blood Glucose Meters

Blood glucose meters are small devices used to measure an individual's blood glucose level at a specific point in time. To use a meter, a person inserts a test strip into the metering device, pricks one of his or her fingers with a lancing device (lancet) to draw a drop of blood, and then puts the blood drop onto the test strip, which causes a chemical reaction based on the presence of glucose in the blood. That chemical reaction can be detected and measured by the meter, which then displays a blood glucose reading, usually within a few seconds. After the reading, the used test strip must be discarded and a new one inserted to conduct a subsequent test.[15]

Continuous Glucose Monitors

Continuous glucose monitoring makes use of a specialized device to automatically track blood glucose levels throughout the day and night. Using a continuous glucose monitor (CGM) allows

[11] U.S. Centers for Disease Control and Prevention, *Type 2 Diabetes, available at* https://www.cdc.gov/diabetes/about/about-type-2-diabetes.html (last visited Mar. 28, 2025).
[12] *Supra* note 1.
[13] World Health Organization, *Mean fasting blood glucose, available at* https://www.who.int/data/gho/indicator-metadata-registry/imrdetails/2380#:~:text=The%20expected%20values%20for%20normal,and%20monitoring%20glycemia%20are%20recommended. (last visited Mar. 28, 2025).
[14] Mayo Clinic, *Diabetic Coma, available at* https://www.mayoclinic.org/diseases-conditions/diabetic-coma/symptoms-causes/syc-20371475 (last visited Mar. 28, 2025).
[15] DiaTribe Learn: Making Sense of Diabetes, *Blood Glucose Meters: Uses, Types, and More* (Jul. 22, 2024), *available at* https://diatribe.org/diabetes-technology/blood-glucose-meters (last visited Mar. 28, 2025).

a diabetic to monitor glucose levels any time at a glance and to review how glucose levels have changed over a few minutes, hours, or days, to see trends, without drawing blood by pricking a finger. Seeing glucose levels in real-time and over periods of time can help diabetics make more informed decisions throughout the day about how to balance food intake, physical activity, and medicines.[16]

CGMs are approved in the U.S. for adults and children with a health care practitioner's prescription, although at least one such device is now available over-the-counter.[17] A CGM works through a tiny sensor inserted under the skin, usually via a small plastic disk or pod adhered to the abdomen or the backside of the upper arm. The sensor measures interstitial glucose level, which is the glucose found in the fluid between the cells. The sensor tests glucose every minute or every few minutes. A transmitter within the sensor wirelessly sends the information to a monitor, which can be a dedicated device or, in some cases, an app on a smartphone.[18]

CGMs are always on and recording glucose levels. Many CGMs have special features that work with information from glucose readings, such as:[19]

- An alarm can sound when the glucose level goes too low or too high.
- Data can be entered manually, regarding meals, physical activity, and medicines, so that such pertinent information can be recorded alongside glucose levels.
- Some models can send information in real-time to a second person's smartphone, such as a parent or caregiver. For example, if a child's glucose drops dangerously low overnight, the CGM could be set to wake a parent in the next room.
- CGM data can be stored on the Internet and made accessible to a diabetic's treating health care practitioner, who can use the data to help monitor and manage the diabetic's treatment.

Benefits of a CGM

Compared with a standard blood glucose meter, using a CGM system can help a diabetic to:[20]

- Better manage blood glucose levels every day.
- Have fewer emergencies relating to hypoglycemia.
- Need fewer finger sticks, which helps because the pain and bruising from repeated finger sticks can discourage the use of a blood glucose meter.

A graphic on the CGM screen shows whether the blood glucose level is rising or dropping, and how quickly it may be rising or dropping, allowing the diabetic to make better decisions about

[16] U.S. Department of Health & Human Services, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, *Continuous Glucose Monitoring, available at:* https://www.niddk.nih.gov/health-information/diabetes/overview/managing-diabetes/continuous-glucose-monitoring (last visited Mar. 28, 2025).
[17] U.S. Food and Drug Administration, *FDA Clears First Over-the-Counter Continuous Glucose Monitor, available at:* https://www.fda.gov/news-events/press-announcements/fda-clears-first-over-counter-continuous-glucose-monitor (last visited Mar. 29, 2025).
[18] *Supra* note 16.
[19] *Id.*
[20] *Id.*

his or her behavior in the short-term regarding the need for insulin, food, or whether exercise is a good or bad idea for that point in time.[21]

Over time, good management of glucose levels greatly helps individuals with diabetes stay healthy and prevent costly and potentially disabling complications of the disease.[22]

The Florida Agency for Health Care Administration

The Florida Agency for Health Care Administration (AHCA) is created under s. 20.42, F.S., to be the chief health policy and planning entity for the state, responsible for health facility licensure, inspection, and regulatory enforcement,[23] as well as the administration of Florida's Medicaid program.[24]

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[25] The federal Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for administering the Medicaid program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians and is financed through state and federal funds.[26]

The AHCA is responsible for establishing and maintaining a Medicaid state plan approved by the CMS, as well as maintaining any Medicaid waivers needed to operate the Florida Medicaid program as directed under the Florida Statutes,[27] the General Appropriations Act (GAA), and other legislation accompanying the GAA.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request from the CMS a formal waiver of the requirements codified in the federal Social Security Act. Federal waivers give states flexibility not afforded through their Medicaid state plan.[28]

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[21] *Id*.
[22] *Id*.
[23] Florida Agency for Health Care Administration, *Health Quality Assurance*, *available at* https://ahca.myflorida.com/health-quality-assurance (last visited Mar. 28, 2025).
[24] Section 409.902, F.S.
[25] Medicaid.gov, *Medicaid*, *available at* https://www.medicaid.gov/medicaid (last visited Mar. 28, 2025).
[26] Section 20.42, F.S.
[27] *See* parts III and IV of ch. 409, F.S., *available at* http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0409/0409.html (last visited Mar. 28, 2025).
[28] Florida Agency for Health Care Administration, *2025 Agency Legislative Bill Analysis: SB 1182* (Feb. 28, 2025) (on file with the Senate Committee on Health Policy).

Approximately 72.5 percent of Florida Medicaid recipients receive services through a Medicaid managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program while the remainder receive services that are paid for on a fee-for-service (FFS) basis.[29, 30] The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and the Prepaid Dental Health Program (Prepaid Dental).[31] Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.[32]

Medicaid Coverage of Prescribed Drugs

Medicaid managed care plans are required to provide all prescription drugs listed on the AHCA's Florida Medicaid Prescribed Drug List (PDL). As such, the AHCA's contracts with the managed care plans prevent them from implementing their own plan-specific formularies or PDLs and require the plans to provide a link to the AHCA's Medicaid PDL on their websites.[33]

Medicaid covers all U.S. Food and Drug Administration (FDA) approved prescription medications. Section 409.91195, F.S., outlines the development and management of the PDL. The AHCA uses clinical factors and its negotiations with drug manufacturers for monetary rebates when determining drugs to include on the PDL. State-negotiated supplemental rebates, along with federally required rebates, frequently result in discounted prescription cost for brand name drugs, potentially resulting in a cost to the state lower than that of its generic equivalent.[34]

Drugs not included on the PDL must be authorized by the AHCA's pharmacy benefit manager (PBM) prior to being dispensed. Additionally, the CMS allows states to cover non-pharmaceutical products under the pharmacy benefit if that product is FDA-approved and has been assigned a National Drug Code (NDC).[35,36]

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[29] The other 27.5 percent of recipients receive Medicaid services through the fee-for-service (FFS) delivery model, where providers contract directly with the AHCA to render services, billing and receiving reimbursement directly from the AHCA; Florida Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).

[30] Florida Agency for Health Care Administration, *Florida Statewide Medicaid Enrollment Report As of February 28, 2025 (including Medikids Population), available at* https://ahca.myflorida.com/content/download/26230/file/ENR_202502.xls (last visited Mar. 28, 2025).

[31] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited Mar. 28, 2025).

[32] *Supra* note 28.

[33] Florida Agency for Health Care Administration, *2023 Agency Legislative Bill Analysis: SB 988* (on file with the Senate Committee on Health Policy).

[34] *Id*.

[35] *Id*.

[36] Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which is a universal product identifier for human drugs; U.S. Food & Drug Administration, *National Drug Code Database Background Information, available at* https://www.fda.gov/drugs/development-approval-process-drugs/national-drug-code-database-background-information (last visited Mar. 28, 2025).

Medicaid Coverage of Durable Medical Equipment

Florida Medicaid reimburses for durable medical equipment (DME) and medical supplies appropriate for use in the recipient's home. DME may be rented, purchased, or rented-to-purchase. Examples of reimbursable equipment and supplies include:[37]

- Augmentative and assistive communication devices;
- Commodes;
- Enteral nutrition supplements;
- Hospital type beds and accessories;
- Mobility aids, including canes, crutches, walkers, and wheelchairs;
- Orthopedic footwear;
- Orthotic and prosthetic devices;
- Ostomy and urological supplies;
- Respiratory equipment and supplies, including nebulizers and oxygen; and
- Suction pumps.

The DME service benefit is one of the minimum covered services for all MMA and LTC plans serving Medicaid enrollees; however, all Medicaid recipients[38] may receive medically necessary DME and medical supplies services in accordance with coverage and limitations requirements[39] established by the AHCA.[40]

Medicaid Coverage of Diabetic Equipment and Supplies

Beginning October 1, 2024, the AHCA transitioned coverage of diabetic equipment and supplies from the DME benefit to be reimbursed through the pharmacy point-of-sale. This transition was authorized under HB 967 (2023), prioritizing both Medicaid recipients and taxpayer dollars as it allowed recipients to acquire diabetic supplies conveniently at a pharmacy and the AHCA to collect rebates for CGMs provided by the pharmacy, which the AHCA was unable to do prior to October 1, 2024.[41]

In order to collect rebates on CGMs and other diabetic supply products, the AHCA entered into a collaborative, multi-state agreement (pool) with the state's contracted pharmacy benefit manager (PBM) and 10 other states, allowing for more rebate negotiation using the state's collective power to reduce costs for CGM products. The AHCA also established a Medicaid Preferred Product List (PPL) that listed the items negotiated through the pool. Products not included on the PPL must be authorized by the AHCA's PBM prior to dispensing.[42]

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[37] Florida Agency for Health Care Administration, *Durable Medical Equipment (DME) and Medical Supplies, available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/medical-and-behavioral-health-coverage-policy/specialized-health-services/durable-medical-equipment-dme-and-medical-supplies (last visited Mar. 28, 2025).
[38] Section 409.906(10), F.S.
[39] Florida Agency for Health Care Administration, *Adopted Rules – Service Specific Policies, available at* https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies (last visited Mar. 28, 2025); *see* rules 59G-4.072, 59G-4.073, 59G-4.074, 59G-4.075, 59G-4.076, and 59G-4.077, F.A.C.
[40] *Supra* note 37.
[41] *Supra* note 28.
[42] *Id*.

Medicaid managed care plans are required to provide all CGMs and related products listed on the AHCA's PPL. As such, the plans cannot implement their own plan-specific formularies or PPLs and are required to provide a link to the AHCA's Medicaid PPL on their website. This allows the AHCA to collect rebates on both FFS and managed care claims. Both clinical factors and drug manufacturers' rebate offers are considered when determining products to include on the PPL.[43]

In 2021, Florida Medicaid spent nearly $40 million on diabetic supplies. Nearly half the expense was for glucose test strips, totaling $19 million for SMMC diabetic enrollees and $500,000 for FFS recipients. Additional diabetic supplies (e.g., glucose sensors, transmitters, insulin pumps,[44] needles, lancets, CGMs, syringes, glucose meters, alcohol swabs) accounted for the remaining approximately $19 million in SMMC diabetic enrollee expenses.[45]

Though most CGMs are covered only by pharmacies, the AHCA still allows CGMs and other diabetic supplies to be provided through the DME benefit under certain circumstances. In an effort to achieve the most patient-centric approach and promote a simplified patient experience, the AHCA has ensured recipients filling a traditional insulin pump are still able to receive their CGM products through a DME provider. To receive an insulin pump from a DME provider, recipients must present a prescription for the insulin pump to the DME provider. Once the prescription is provided, the insulin pump associated with Healthcare Common Procedure Coding System (HCPCS) code[46] E0784 and all related supplies, including the associated CGM, will be covered. If a recipient is not eligible to receive an insulin pump from a DME provider, they must get their CGM product(s) at the pharmacy.[47]

The Florida Medicaid Diabetic Supply Services Coverage Policy,[48] as well as the Diabetic Supply Criteria,[49] can be viewed on the AHCA's website.[50]

III. Effect of Proposed Changes:

Section 1 creates a non-statutory section of the Laws of Florida to require the AHCA, within 30 days after this bill becomes a law, to seek federal approval through a Medicaid waiver or state plan amendment as needed to provide coverage of CGMs and related supplies as a DME benefit

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[43] *Id*.
[44] An insulin pump is a device that delivers insulin continuously and on-demand, mimicking the pancreas. Pumps deliver insulin through a tiny catheter that goes in a fleshy area of the body; Cleveland Clinic, *Type 1 Diabetes, available at* https://my.clevelandclinic.org/health/diseases/21500-type-1-diabetes#management-and-treatment (last visited Mar. 29, 2025).
[45] *Supra* note 33.
[46] HCPCS codes are developed by the CMS and maintained by the American Medical Association. HCPCS codes are one of the primary medical languages used by health care providers to bill for procedures and services rendered; Centers for Medicare & Medicaid Services, *Healthcare Common Procedure Coding System (HCPCS), available at* https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system (last visited Mar. 28, 2025).
[47] *Supra* note 28.
[48] Florida Agency for Health Care Administration, *Florida Medicaid Diabetic Supply Services Coverage Policy* (Sep. 2024), *available at* https://ahca.myflorida.com/content/download/25105/file/59G-4.252%20Diabetic%20Supply%20Services%20Coverage%20Policy_FINAL.pdf (last visited Mar. 28, 2025).
[49] Florida Agency for Health Care Administration, *Diabetic Supply Criteria, available at* https://ahca.myflorida.com/content/download/25202/file/Diabetic_Supply_Criteria.pdf (last visited Mar. 29, 2025).
[50] Florida Agency for Health Care Administration, *Diabetic Supply Services, available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/pharmacy-policy/diabetic-supply-services (last visited Mar. 29, 2025).

for Medicaid recipients. The bill requires that a licensed DME provider be reimbursed for CGMs and related supplies, provided the claim is submitted through an active Medicare HCPCS. Under the bill, the AHCA may not require such provider to use an NDC number as part of such claim submission.

The bill indicates that it does not preclude the AHCA from providing additional coverage of CGMs as a Medicaid pharmacy benefit.

The AHCA must begin implementation of the bill's provisions upon receiving any necessary federal approval.

Section 2 provides that the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The AHCA anticipates a fiscal impact of approximately $10 million dollars annually. This estimate was calculated using the potential loss of rebates through the pharmacy

benefit and the increased cost incurred from the utilization of non-preferred CGMs and related supplies provided through the DME benefit. The two primary inputs affecting loss of rebates are as follows:[51]

- The AHCA's participation in pooled rebate negotiation is limited to collecting rebates for products listed on the PPL. The bill would allow all CGM products, including those not included on the PPL, to be available through the DME benefit, which means that any product not provided by a pharmacy would not be eligible for a rebate.
- Rebate collection requires NDC reporting to capture the exact products that are dispensed, to accurately invoice manufacturers. This bill prohibits NDC reporting for products billed by a DME provider, which would prevent the state from collecting rebates on any products filled through the DME benefit.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill creates undesignated sections of the Laws of Florida.

IX. Additional Information:

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[51] *Supra* note 28.

By Senator Harrell

31-01149A-25 20251182__

A bill to be entitled

An act relating to Medicaid coverage of continuous glucose monitors; requiring the Agency for Health Care Administration to, within a specified timeframe, seek federal approval as needed to provide coverage of continuous glucose monitors and related supplies as a durable medical equipment benefit under the Medicaid program; providing for the reimbursement of such equipment; providing construction; requiring the agency to implement these changes upon receiving any necessary federal approval; providing an effective date.

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

Section 1. (1) Within 30 days after this act becomes a law, the Agency for Health Care Administration shall seek federal approval through a Medicaid waiver or state plan amendment as needed to provide coverage of continuous glucose monitors and related supplies as a durable medical equipment benefit for Medicaid recipients. A licensed durable medical equipment provider must be reimbursed for continuous glucose monitors and related supplies, provided the claim is submitted through an active Medicare Healthcare Common Procedure Coding System. The agency may not require such provider to use a National Drug Code number as part of such claim submission.

(2) This section does not preclude the agency from providing additional coverage of continuous glucose monitors as a Medicaid pharmacy benefit.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(3) The agency shall begin implementation of these changes upon receiving any necessary federal approval.

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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Higher Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

SENATOR GAYLE HARRELL
31st District

March 12, 2025

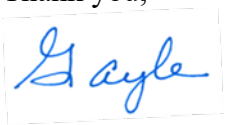
Senator Burton
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Burton,

I respectfully request that SB 1182 –Medicaid Coverage of Continuous Glucose Monitors be placed on the next available agenda for the Health Policy Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,



Senator Gayle Harrell
Senate District 31

Cc: Allen Brown, Staff Director
Anhar Al-Asadi, Committee Administrative Assistant

REPLY TO:
❒ 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
❒ 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

Tab 26

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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4/1/25
Meeting Date

S. Health Policy
Committee

1182
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jennifer Ungrue

Phone 850-419-5100

Address
Street

Email jungrue@joneswalker.com

City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
OneSource Medical

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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04/01/2025
Meeting Date

Health Policy
Committee

SB 1182
Bill Number or Topic

Amendment Barcode (if applicable)

Name Edda Fernandez

Phone 954-850-7262

Address 215 Monroe Street 603
Street

Email ifernandez@aarp.org

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

4/1/2025
Meeting Date

Health Policy
Committee

SB 1182
Bill Number or Topic

Amendment Barcode (if applicable)

Name David Mica, Jr.

Phone 8502229800

Address 306 E College Ave
Street

Email Davidm@fha.org

Tallahassee FL 32312
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Hospital Association

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

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

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S-001 (08/10/2021)

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Committee on Health Policy **Judge:**

Started: 4/1/2025 1:35:15 PM
Ends: 4/1/2025 3:26:20 PM Length: 01:51:06

1:35:15 PM	Call to Order-Chair Burton
1:35:37 PM	Roll Call
1:35:41 PM	Quorum Present
1:36:30 PM	Opening Remarks
1:37:32 PM	SB 596 TPed
1:37:37 PM	Motion for Reconsideration on SB 1606
1:37:48 PM	Senator Gaetz
1:37:55 PM	Tab 1 SB 1606
1:37:58 PM	Senator Grall
1:38:30 PM	Amendment #332792
1:38:35 PM	Senator Grall
1:39:10 PM	Adopted
1:39:13 PM	Motion for Reconsideration of Amendment # 900268
1:39:28 PM	Senator Gaetz
1:39:40 PM	Substitute Amendment # 894726 to Amendment # 900268
1:39:53 PM	Senator Grall
1:40:07 PM	Adopted
1:40:20 PM	Senator Berman
1:40:45 PM	Senator Grall
1:41:02 PM	Senator Berman
1:41:13 PM	Senator Grall
1:42:00 PM	Public Testimony
1:42:19 PM	Bill Cotterall Florida Justice Association
1:42:55 PM	Times Waived Read into Record
1:43:13 PM	Roll Call for SB 1606
1:43:45 PM	Reported Favorably
1:43:51 PM	Tabs 3-6 Confirmations
1:44:32 PM	Motion to Recommend Confirmation
1:44:33 PM	Senator Gaetz
1:44:35 PM	Roll Call for Tabs 3-6
1:44:40 PM	Recommended Favorably
1:45:20 PM	Tab 2 AHCA Confirmation-Shevaun Harris, Secretary of AHCA
1:45:32 PM	Committee Witness Oath
1:45:38 PM	Shevaun Harris
1:52:31 PM	Senator Davis
1:54:16 PM	Shevaun Harris
1:55:38 PM	Senator Gaetz
1:56:48 PM	Shevaun Harris
1:59:19 PM	Times Waived Read into Record
2:00:25 PM	Senator Harrell
2:01:02 PM	Senator Davis
2:02:22 PM	Motion to Recommend Confirmation
2:02:25 PM	Senator Harrell
2:02:46 PM	Roll Call for Confirmation
2:03:03 PM	Recommended Favorably
2:03:35 PM	Tab 8
2:03:50 PM	Senator Trumbull
2:05:09 PM	Amendment #883178
2:05:23 PM	Senator Trumbull
2:05:47 PM	Adopted
2:06:00 PM	Times Waived Read into Record
2:06:09 PM	Roll Call for SB 28

2:06:17 PM Reported Favorably
2:06:40 PM Tab 11 CS/SB 772
2:06:55 PM Senator Calatayud
2:07:34 PM Times Waived Read into Record
2:07:49 PM Roll Call for CS/SB 772
2:08:03 PM Reported Favorably
2:08:15 PM Tab 12 SB 998
2:08:37 PM Senator Calatayud
2:09:10 PM Amendment #475642
2:09:25 PM Senator Calatayud
2:09:43 PM Times Waived Read into Record
2:09:54 PM Adopted
2:10:33 PM Times Waived Read into Record
2:10:40 PM Roll Call for SB 998
2:10:58 PM Reported Favorably
2:11:18 PM Tab 13 SB 1412
2:11:23 PM Senator Calatayud
2:12:42 PM Senator Davis
2:13:06 PM Senator Calatayud
2:15:02 PM Times Waived Read into Record
2:15:21 PM Roll Call for SB 1412
2:15:26 PM Reported Favorably
2:15:51 PM Tab 14 SB 1800
2:16:09 PM Late Filed Amendment #614080
2:16:21 PM Senator Calatayud
2:17:32 PM Times Waived Read into Record
2:17:40 PM Adopted
2:17:58 PM Times Waived Read into Record
2:18:20 PM Roll Call for SB 1800
2:18:26 PM Reported Favorably
2:18:39 PM Tab 9 SB 306
2:19:14 PM Senator Sharief
2:19:24 PM Amendment #931448
2:19:35 PM Senator Sharief
2:19:55 PM Adopted
2:20:18 PM Times Waived Read into Record
2:20:34 PM Senator Sharief
2:21:32 PM Roll Call for SB 306
2:21:42 PM Reported Favorably
2:22:18 PM Tab 16 SB 1768
2:22:27 PM Senator Trumbull
2:22:31 PM Late Filed Amendment #947004
2:22:39 PM Senator Trumbull
2:24:02 PM Adopted
2:24:13 PM Times Waived Read into Record
2:24:31 PM Roll Call for SB 1768
2:24:55 PM Reported Favorably
2:25:13 PM Tab 7 SB 22
2:25:31 PM Senator Rodriguez
2:26:02 PM Times Waived Read into Record
2:26:10 PM Senator Rodriguez
2:26:14 PM Roll Call for SB 22
2:26:20 PM Reported Favorably
2:26:42 PM Tab 17 SB 1602
2:26:53 PM Senator Harrell
2:27:38 PM Amendment #722464
2:28:42 PM Senator Harrell
2:29:29 PM Adopted
2:29:48 PM Times Waived Read into Record
2:29:57 PM Roll Call for SB 1602
2:30:24 PM Reported Favorably
2:30:31 PM Tab 18 SB 1156

2:30:37 PM Senator Harrell
2:32:38 PM Senator Berman
2:32:56 PM Amendment #735504
2:33:18 PM Senator Harrell
2:33:36 PM Senator Berman
2:34:57 PM Senator Harrell
2:35:54 PM Adopted
2:36:15 PM Times Waived Read into Record
2:36:56 PM Senator Harrell
2:37:01 PM Roll Call for SB 1156
2:37:16 PM Reported Favorably
2:37:30 PM Tab 19 SB 1490
2:37:37 PM Senator Harrell
2:38:27 PM Amendment #865162
2:39:28 PM Senator Harrell
2:40:52 PM Adopted
2:40:58 PM Senator Davis
2:41:39 PM Senator Harrell
2:42:49 PM Senator Davis
2:43:08 PM Senator Harrell
2:43:42 PM Senator Davis
2:44:09 PM Senator Harrell
2:44:42 PM Times Waived Read into Record
2:45:00 PM Senator Harrell
2:45:56 PM Roll Call SB 1490
2:46:22 PM Reported Favorably
2:46:27 PM Tab 20 SB 1182
2:46:43 PM Senator Harrell
2:47:26 PM Times Waived Read into Record
2:47:40 PM Roll Call for SB 1182
2:47:55 PM Reported Favorably
2:48:10 PM Tab 10 SB 1270
2:48:23 PM Senator Collins
2:48:35 PM Amendment #275506
2:48:42 PM Senator Collins
2:50:34 PM Amendment to Amendment #978704
2:50:43 PM Senator Collins
2:51:29 PM Public Testimony
2:51:34 PM Ryan Bradley, Florida Academy of Physicians Assistants
2:53:47 PM Times Waived Read into Record
2:53:59 PM Adopted
2:54:08 PM Amendment to Amendment #159816
2:54:21 PM Senator Collins
2:54:27 PM Adopted
2:54:54 PM Public Testimony
2:55:03 PM Katherine Henry
2:56:56 PM Maya Hahn
2:59:38 PM Karoline Stancik
3:01:51 PM Times Waived Read into Record
3:03:16 PM Adopted
3:04:28 PM Senator Berman
3:04:51 PM Senator Collins
3:05:52 PM Senator Davis
3:06:10 PM Senator Collins
3:06:36 PM Senator Davis
3:07:11 PM Senator Collins
3:07:30 PM Chair Burton
3:08:11 PM Senator Davis
3:08:18 PM Staff Member-Dan Looke
3:08:38 PM Senator Collins
3:08:45 PM Senator Davis
3:09:39 PM Senator Collins

3:09:56 PM Senator Harrell
3:10:46 PM Senator Collins
3:11:09 PM Senator Harrell
3:11:26 PM Senator Collins
3:11:34 PM Senator Harrell
3:11:39 PM Senator Collins
3:11:49 PM Senator Harrell
3:12:02 PM Senator Collins
3:12:51 PM Senator Osgood
3:13:43 PM Senator Collins
3:13:56 PM Senator Osgood
3:14:36 PM Senator Collins
3:15:13 PM Senator Osgood
3:15:59 PM Senator Collins
3:16:10 PM Public Testimony
3:16:37 PM Ted Macie
3:19:40 PM Maya Hahn
3:20:31 PM Senator Osgood
3:20:57 PM Senator Trumbull
3:21:06 PM Time Certain Motion
3:21:10 PM Adopted
3:21:29 PM Times Waived Read into Record
3:21:42 PM Senator Harrell
3:22:29 PM Senator Berman
3:23:15 PM Senator Collins
3:24:13 PM Roll Call for SB 1270
3:24:46 PM Reported Favorably
3:24:53 PM Senator Leek- Recording Votes
3:25:12 PM Senator Berman-Recording Votes
3:25:16 PM Senator Osgood-Recording Votes
3:25:34 PM Closing Remarks
3:26:20 PM Adjourned