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| **Tab 1** | **SPB 7032** by **AHS;** Medicaid Enrollment for Permanently Disabled Individuals |

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| **Tab 2** | **CS/SB 306** by **HP, Sharief (CO-INTRODUCERS) Gaetz, Davis;** Similar to H 00389 Medicaid Providers |

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| **Tab 3** | **SB 524** by **Harrell;** Similar to CS/H 01089 Newborn Screenings |

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| 342978 | A | S | RCS | AHS, Harrell | Delete L.38: | 04/10 04:58 PM |

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| **Tab 4** | **CS/SB 584** by **HE, Garcia (CO-INTRODUCERS) Osgood;** Similar to CS/CS/H 00879 Young Adult Housing Support |

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| **Tab 5** | **SB 788** by **Truenow (CO-INTRODUCERS) Gaetz;** Similar to CS/H 00797 Veterans' Nursing Homes |

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| **Tab 6** | **CS/SB 976** by **CF, Bernard;** Identical to CS/H 00901 Court-appointed Psychologists |

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| **Tab 7** | **CS/SB 1156** by **HP, Harrell;** Similar to CS/CS/H 01529 Home Health Aide for Medically Fragile Children Program |

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| **Tab 8** | **CS/SB 1174** by **CF, Jones (CO-INTRODUCERS) Rouson;** Similar to CS/CS/H 00989 Licensure of Family Foster Homes |

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| 166904 | A | S | RCS | AHS, Jones | Delete L.33 - 37: | 04/10 05:03 PM |

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| **Tab 9** | **CS/SB 1270** by **HP, Collins;** Similar to CS/H 01299 Department of Health |

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| **Tab 10** | **CS/SB 1354** by **CF, Trumbull;** Similar to CS/CS/H 00633 Behavioral Health Managing Entities |

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| **Tab 11** | **SB 1412** by **Calatayud;** Similar to CS/H 01353 Home Health Care Services |

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| **Tab 12** | **CS/SB 1490** by **HP, Harrell;** Similar to CS/H 01085 Children's Medical Services Program |

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| 649872 | A | S | RCS | AHS, Harrell | Delete L.643: | 04/10 05:07 PM |

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| **Tab 13** | **SB 1568** by **Brodeur;** Similar to 1ST ENG/H 01297 Electronic Prescribing |

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| 584482 | A | S | RS | AHS, Brodeur | Delete L.31 - 64: | 04/10 05:08 PM |
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| **Tab 14** | **CS/SB 1606** by **HP, Grall (CO-INTRODUCERS) Bradley;** Similar to CS/H 01083 Patient Access to Records |

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| **Tab 15** | **CS/SB 1620** by **CF, Rouson;** Compare to CS/H 01439 Mental Health and Substance Use Disorders |

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| **Tab 16** | **CS/SB 1736** by **CF, Grall (CO-INTRODUCERS) Sharief, Bradley;** Similar to CS/H 01567 Insulin Administration by Direct-support Professionals and Relatives |

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| 574242 | A | S | RCS | AHS, Grall | Delete L.97: | 04/10 05:15 PM |

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| **Tab 17** | **CS/SB 1768** by **HP, Trumbull;** Similar to CS/H 01617 Stem Cell Therapy |

| **Tab 18** | **CS/SB 1800** by **HP, Calatayud;** Similar to CS/CS/H 01545 Parkinson's Disease | | | | | |
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| 121756 | A | S | RCS | AHS, Calatayud | Delete L.40 - 69: | 04/10 05:16 PM |

| **Tab 19** | **CS/SB 1808** by **HP, Burton;** Compare to H 01513 Refund of Overpayments Made by Patients |
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| **Tab 20** | **CS/SB 1842** by **HP, Burton;** Compare to 1ST ENG/H 01101 Out-of-network Providers | | | | | |
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| 416222 | A | S | RCS | AHS, Burton | Delete L.34 - 39: | 04/10 05:18 PM |

**The Florida Senate**

# COMMITTEE MEETING EXPANDED AGENDA

## APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES
## Senator Trumbull, Chair
## Senator Davis, Vice Chair

**MEETING DATE:** Thursday, April 10, 2025
**TIME:** 8:30—10:30 a.m.
**PLACE:** *Pat Thomas Committee Room,* 412 Knott Building

**MEMBERS:** Senator Trumbull, Chair; Senator Davis, Vice Chair; Senators Berman, Brodeur, Burton, Garcia, Gruters, Harrell, Rodriguez, and Rouson

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| | Consideration of proposed bill: | | |
| 1 | **SPB 7032** | Medicaid Enrollment for Permanently Disabled Individuals; Requiring that certain persons who receive specified Medicaid-covered services and who are permanently disabled be presumed eligible for continued Medicaid coverage during redetermination processes; requiring the Agency for Health Care Administration to continue to make payments for such services; requiring certain persons to notify the agency and the Department of Children and Families of certain changes in disability or economic status; requiring the agency to seek federal authorization to exempt certain persons from annual redetermination of eligibility, etc.<br><br>**(Preliminary Draft Available - final draft will be made available at least 24 hours prior to the meeting)** | Submitted and Reported Favorably as Committee Bill<br>Yeas 8 Nays 0 |
| 2 | **CS/SB 306**<br>Health Policy / Sharief<br>(Similar H 389) | Medicaid Providers; Requiring the Agency for Health Care Administration to include specified requirements in its contracts with Medicaid managed care plans, etc.<br><br>HP 04/01/2025 Fav/CS<br>AHS 04/10/2025 Favorable<br>FP | Favorable<br>Yeas 8 Nays 0 |
| 3 | **SB 524**<br>Harrell<br>(Similar CS/H 1089) | Newborn Screenings; Beginning on a specified date, requiring that the Department of Health's rules require that newborns be screened for Duchenne muscular dystrophy at the appropriate age, etc.<br><br>HP 03/25/2025 Favorable<br>AHS 04/10/2025 Fav/CS<br>FP | Fav/CS<br>Yeas 8 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 4 | **CS/SB 584**<br>Education Postsecondary / Garcia<br>(Similar CS/H 879) | Young Adult Housing Support; Requiring each Florida College System institution and state university to develop plans for prioritizing the placement of certain students; requiring the Department of Children and Families, community-based care lead agencies, and housing authorities to take any action required by the United States Department of Housing and Urban Development to administer the federal Foster Youth to Independence initiative; requiring the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct a study of the barriers to housing faced by young adults who are homeless or were formerly in foster care, etc.<br><br>HE 03/31/2025 Fav/CS<br>AHS 04/10/2025 Favorable<br>FP | Favorable<br>Yeas 8 Nays 0 |
| 5 | **SB 788**<br>Truenow<br>(Similar CS/H 797) | Veterans' Nursing Homes; Defining the term "veteran- and spouse-designated nursing home beds"; authorizing the executive director of the Department of Veterans' Affairs to approve requests to create or modify veteran- and spouse-designated nursing home beds if certain conditions are met; authorizing the department to adopt rules, etc.<br><br>MS 03/25/2025 Favorable<br>AHS 04/10/2025 Favorable<br>FP | Favorable<br>Yeas 8 Nays 0 |
| 6 | **CS/SB 976**<br>Children, Families, and Elder Affairs / Bernard<br>(Identical CS/H 901) | Court-appointed Psychologists; Requiring a party to seek disqualification of a court-appointed psychologist before filing an administrative complaint against the psychologist; providing for disqualification motions; revising provisions for award of costs and attorney fees in supplemental actions against court-appointed psychologists, etc.<br><br>CF 04/01/2025 Fav/CS<br>AHS 04/10/2025 Favorable<br>FP | Favorable<br>Yeas 8 Nays 0 |
| 7 | **CS/SB 1156**<br>Health Policy / Harrell<br>(Similar CS/H 1529, Compare S 1166) | Home Health Aide for Medically Fragile Children Program; Providing requirements for the annual assessment of the home health aide for medically fragile children program; 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 to seek federal approval, including a federal waiver or state plan amendment, for specified purposes, etc.<br><br>HP 04/01/2025 Fav/CS<br>AHS 04/10/2025 Favorable<br>FP | Favorable<br>Yeas 8 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 8 | **CS/SB 1174**<br>Children, Families, and Elder Affairs / Jones<br>(Similar CS/CS/H 989) | Licensure of Family Foster Homes; Requiring the Department of Children and Families to adopt rules to ensure that certain licensees may amend their licenses without submitting new applications and that the amended license process receives priority, etc.<br><br>CF 03/12/2025 Fav/CS<br>AHS 04/10/2025 Fav/CS<br>RC | Fav/CS<br>Yeas 8 Nays 0 |
| 9 | **CS/SB 1270**<br>Health Policy / Collins<br>(Similar CS/H 1299) | Department of Health; Repealing a provision which provides for the repeal of the definition of the term “messenger ribonucleic acid vaccine”; 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; authorizing certain physician assistants to be issued temporary certificates for practice in areas of critical need, etc.<br><br>HP 04/01/2025 Fav/CS<br>AHS 04/10/2025 Fav/CS<br>RC | Fav/CS<br>Yeas 5 Nays 3 |
| 10 | **CS/SB 1354**<br>Children, Families, and Elder Affairs / Trumbull<br>(Similar CS/CS/H 633) | Behavioral Health Managing Entities; Requiring the Department of Children and Families to contract biennially for specified functions; requiring the department to contract for recommendations for certain transparency improvements; requiring the department to prepare and present to the Governor and Legislature a specified final report by a specified date; requiring managing entities to report required data to the department in a standardized electronic format, etc.<br><br>CF 03/25/2025 Fav/CS<br>AHS 04/10/2025 Favorable<br>FP | Favorable<br>Yeas 8 Nays 0 |
| 11 | **SB 1412**<br>Calatayud<br>(Similar CS/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.<br><br>HP 04/01/2025 Favorable<br>AHS 04/10/2025 Favorable<br>RC | Favorable<br>Yeas 8 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 12 | **CS/SB 1490**<br>Health Policy / Harrell<br>(Similar CS/H 1085, S 1166) | 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 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.<br><br>HP 04/01/2025 Fav/CS<br>AHS 04/10/2025 Fav/CS<br>FP | Fav/CS<br>Yeas 8 Nays 0 |
| 13 | **SB 1568**<br>Brodeur<br>(Similar H 1297) | Electronic Prescribing; Revising health care practitioners who may only electronically transmit prescriptions for certain drugs; revising exceptions, etc.<br><br>HP 03/25/2025 Favorable<br>AHS 04/10/2025 Fav/CS<br>RC | Fav/CS<br>Yeas 8 Nays 0 |
| 14 | **CS/SB 1606**<br>Health Policy / Grall<br>(Similar CS/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.<br><br>HP 03/25/2025 Pending reconsideration (Unfavorable)<br>HP 04/01/2025 Reconsidered (Fav/CS)<br>AHS 04/10/2025 Favorable<br>RC | Favorable<br>Yeas 5 Nays 3 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
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| 15 | **CS/SB 1620**<br>Children, Families, and Elder Affairs / Rouson<br>(Compare CS/H 1439) | Mental Health and Substance Use Disorders; Defining the term "person-first language"; revising the minimum standards for a mobile crisis response service; requiring that an individualized treatment plan be reevaluated within a specified timeframe to ensure the recommended care remains necessary for a patient; requiring the Department of Children and Families to review and evaluate the discharge procedures and policies for all receiving facilities; requiring the department to reevaluate assessment services at specified intervals to ensure a patient's clinical needs are being met, etc.<br><br>CF 03/25/2025 Fav/CS<br>AHS 04/10/2025 Favorable<br>FP | Favorable<br>Yeas 8 Nays 0 |
| 16 | **CS/SB 1736**<br>Children, Families, and Elder Affairs / Grall<br>(Similar CS/H 1567) | Insulin Administration by Direct-support Professionals and Relatives; Defining the term "direct-support professional"; authorizing direct-support professionals and relatives of clients in group home facilities for individuals with developmental disabilities to administer insulin as prescribed to the client if specified conditions are met, etc.<br><br>CF 03/19/2025 Fav/CS<br>AHS 04/10/2025 Fav/CS<br>RC | Fav/CS<br>Yeas 8 Nays 0 |
| 17 | **CS/SB 1768**<br>Health Policy / Trumbull<br>(Similar CS/H 1617) | Stem Cell Therapy; Authorizing physicians to perform stem cell therapy not approved by the United States Food and Drug Administration under certain circumstances; requiring physicians to provide a specified written notice to patients before performing any stem cell therapy; requiring physicians to obtain written consent from the patient or his or her representative before performing the therapy, etc.<br><br>HP 04/01/2025 Fav/CS<br>AHS 04/10/2025 Favorable<br>RC | Favorable<br>Yeas 7 Nays 1 |
| 18 | **CS/SB 1800**<br>Health Policy / Calatayud<br>(Similar CS/CS/H 1545, Compare H 1547, Linked S 1802) | Parkinson's Disease; Creating the "Parkinson's Disease Research Act"; establishing the Consortium for Parkinson's Disease Research within the University of South Florida; establishing the Parkinson's Disease Research Board; requiring the board to direct the operations of the consortium and to annually adopt a plan for Parkinson's disease research; requiring the board to award funds to board members for certain purposes, etc.<br><br>HP 04/01/2025 Fav/CS<br>AHS 04/10/2025 Fav/CS<br>FP | Fav/CS<br>Yeas 8 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 19 | **CS/SB 1808**<br>Health Policy / Burton<br>(Compare H 1513) | Refund of Overpayments Made by Patients; Requiring health care facility licensees to refund to the patient any overpayment within a specified timeframe; providing applicability; specifying that health care facility licensees who violate certain provisions are subject to administrative fines; requiring health care practitioners to refund to the patient any overpayment within a specified timeframe; revising the acts that constitute grounds for disciplinary actions for health care practitioners, etc.<br><br>HP 03/18/2025 Fav/CS<br>AHS 04/10/2025 Favorable<br>RC | Favorable<br>Yeas 8 Nays 0 |
| 20 | **CS/SB 1842**<br>Health Policy / Burton<br>(Compare H 1101) | Out-of-network Providers; Requiring a health care practitioner or his or her employee to confirm whether a referral provider participates in the provider network of the patient's health insurer or health maintenance organization under certain circumstances; requiring a health care practitioner to notify a patient in writing that certain services are not covered services under the patient's health coverage; providing for health care practitioner disciplinary action under certain conditions, etc.<br><br>HP 03/25/2025 Fav/CS<br>AHS 04/10/2025 Fav/CS<br>FP | Fav/CS<br>Yeas 5 Nays 3 |
| | 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | SB 7032 |
| INTRODUCER: | Appropriations Committee on Health and Human Services |
| SUBJECT: | Medicaid Enrollment for Permanently Disabled Individuals |
| DATE: | April 14, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Barr | McKnight | | **AHS Submitted as Comm. Bill/FAV** |

## I. Summary:

SB 7032 provides presumptive eligibility to permanently disabled individuals receiving Medicaid-covered institutional care, hospice, or home and community-based services and requires the Agency for Health Care Administration (AHCA) to continue payments unless there is a material change in the individual's disability or economic status that affects eligibility.

The bill requires covered individuals, caregivers, or responsible parties to notify the AHCA and the Department of Children and Families (DCF) of any change in disability or economic status. The DCF may then conduct eligibility redeterminations and must notify the individual or caregiver of the start and result of such redetermination.

The bill also requires the AHCA to seek federal approval to exempt permanently disabled Medicaid-qualified individuals from annual eligibility redeterminations. The AHCA and the DCF are required to establish a process to facilitate notification of changes impacting eligibility.

The bill will have a significant negative fiscal impact on the DCF and an indeterminate negative fiscal impact on the Florida Medicaid Program. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

### Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds.[1] The AHCA delegates certain functions to other state

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).

agencies, including the Department of Children and Families (DCF), the Agency for Persons with Disabilities (APD), the Department of Health (DOH), and the Department of Elderly Affairs (DOEA).

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services (HHS) to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Section 1115 of the Social Security Act allows states to implement demonstrations of innovative service delivery systems that improve care, increase efficiency, and reduce costs. These laws allow HHS to waive federal requirements to expand populations or services, or to try new ways of service delivery.

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program. Florida also has waivers under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program and the Development Disabilities Individual Budgeting (iBudget) Waiver.[4]

Federal Medicaid law establishes coverage for institutional care, such as nursing home care and residential institutions for people with developmental disabilities but does not allow federal dollars to be spent on alternatives to such care. Those alternatives include home- and community-based services (HCBS) designed to keep people in their homes and communities instead of going into an institution when they need higher levels of care. This federal spending limitation creates a bias toward institutional care, and toward acute care, rather than allowing the non-acute supports that avoid institutionalization.

***Long-Term Care Home and Community-Based Services Program***

Florida obtained a federal waiver to allow the state Medicaid program to cover HCBS long-term care services for elders and people with disabilities,[5] to prevent admission into a nursing home.

[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] S. 409.964, F.S.
[5] S. 409.979, F.S. Individuals 65 years of age or older and in need of nursing facility level of care; or 18 years of age or older and eligible for Medicaid by reason of a disability and in need of nursing facility level of care.

***iBudget Home and Community-Based Services Waiver Program***

The AHCA oversees the Medicaid HCBS program for individuals with specified developmental disabilities through a federal waiver administered by the APD, known as iBudget. The purpose of the waiver is to:[6]

- Promote and maintain the health and welfare of individuals with developmental disabilities;
- Provide medically necessary supports and services to delay or prevent institutionalization; and
- Foster the principles of self-determination as a foundation for services and supports.

The iBudget provides HCBS to eligible persons with developmental disabilities living at home or in a home-like setting. Eligible diagnoses include disorders or syndromes attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome. The disorder must manifest before the age of 18, and it must constitute a substantial handicap that can reasonably be expected to continue indefinitely.[7]

The iBudget program allocates available funding through an algorithm, providing each client an established budget with the flexibility to choose from the authorized array of services that best meet their individual needs within their community.[8]

**Medicaid Eligibility**

Medicaid eligibility in Florida is determined either by the DCF or the Social Security Administration (SSA) for Supplemental Security Income (SSI) recipients. Since Medicaid is designed for low-income individuals, Medicaid eligibility is based on an evaluation of the individual's income and assets.

Section 1614(3) of the Social Security Act provides that an individual shall be considered to be disabled if they are unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months. Further, an individual under the age of 18 shall be considered disabled if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Under Florida's Medicaid State Plan, permanent and total disability is a physical or mental condition of major significance which is expected to continue throughout the lifetime of an individual and is not expected to be removed or substantially improved by medical treatment. It is expected to continue for a prolonged period of disability and the eventual prognosis may be

[6] Agency for Health Care Administration, *Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook (May 2023), available at* https://apd.myflorida.com/ibudget/docs/iBudget%20Handbook%20with%20ADT%20Redesign%20Final.pdf (last visited Apr. 7, 2025).
[7] S. 393.063(11), F.S.
[8] S. 393.0662(1), F.S.

indefinite. Total disability exists when a permanent impairment, or a combination of permanent impairments, substantially precludes the individual from engaging in a useful occupation.

The DCF uses the same criteria that the SSA uses to determine disability for benefits. If the SSA determines an individual is disabled, the DCF adopts their disability decision. If an individual does not have a disability decision from the SSA, then the DCF must obtain a disability determination based on the individual's circumstances.[9]

The DOEA is responsible for conducting clinical level of care evaluations under the LTC Waiver, while the APD is responsible for conducting clinical level of care evaluations under the iBudget Waiver. To be eligible for Medicaid under 1915(c) waivers, the individual must be determined to need the level of care provided by a hospital, nursing home, or intermediate care facility for the developmentally disabled.[10] The clinical level of care is determined during an initial evaluation and the individual must be reevaluated at least annually.[11]

Federal regulations require the DCF make a redetermination of eligibility without requiring information from the individual if it is possible to make a redetermination based on reliable information contained in the individual's account or obtained from another state agency or federal agency.[12] If the DCF is unable to verify the individual's eligibility, they send the recipient a renewal notice, electronically and by mail, requesting the required information to make an eligibility determination.[13]

Between April 2023 and February 2025, approximately 534 disabled individuals lost Medicaid coverage[14] because they failed to provide information requested by the DCF to make an eligibility determination.[15] The number of individuals who may have remained eligible for Medicaid had they submitted the requested information to the DCF is unknown. During the same period, approximately 3,357 disabled individuals lost Medicaid coverage due to not meeting income and asset eligibility requirements.[16]

## III. Effect of Proposed Changes:

**Section 1** amends s. 409.904, F.S., to provide presumptive Medicaid eligibility to individuals who are permanently disabled and receiving institutional care, hospice, or home and community-based services, during any redetermination process.

The bill requires the Agency for Health Care Administration (AHCA) to continue payments for these services unless a material change in the individual's disability or economic status results in ineligibility and requires that individuals, caregivers, or responsible parties notify the AHCA and

[9] Department of Children and Families, *House Bill 1227 Bill Analysis* (Mar. 17, 2025)(on file with Senate Appropriations Committee on Health and Human Services).
[10] 42 C.F.R., § 441.301(b).
[11] 42 C.F.R., § 441.302(c).
[12] 42 C.F.R., § 435.916.
[13] *Supra* note 9.
[14] Includes the following categories of Medicaid that cover disabled populations: Family Related Medicaid; Long-term Care Medicaid; HCBS Waiver Medicaid; Community Hospice Medicaid; and Medicaid for Aged and Disabled (MEDS-AD).
[15] *Supra* note 9.
[16] *Id.*

the Department of Children and Families (DCF) of any such changes. The DCF is then authorized to conduct a redetermination and required to notify the individual, caregiver, or responsible party before and, at its conclusion, the results of the redetermination.

The bill requires the AHCA to seek federal approval by October 1, 2025, to exempt permanently disabled Medicaid recipients from annual redetermination. For this exemption, the term "permanently disabled" means that a person has been determined to be disabled under s. 409.904(1)(a), F.S., and has had his or her qualifying disability certified by a physician licensed under ch. 458 or ch. 459, F.S., as permanent.

In addition, the bill requires the AHCA and the DCF to develop a process to facilitate required notifications.

**Section 2** provides that the bill takes effect 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 bill is expected to have a significant negative fiscal impact of $708,000 on the Department of Children and Families to update their online Medicaid application platform, the Florida System (ACCESS).[17] Based on an analysis of the unreserved cash in DCF's trust funds, the costs to the department can be absorbed within existing resources.

The bill will have an indeterminate negative fiscal impact on the Florida Medicaid Program.[18] Because the exemption is limited to individuals with medically verified, permanent disabilities, the potential for ineligible individuals remaining enrolled is expected to be minimal, given the eligibility criteria and required physician certification. However, the cost of providing continued Medicaid coverage to any ineligible individuals within this group is indeterminate.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 409.904 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.



[17] Department of Children and Families, *House Bill 1227 Bill Analysis* (Mar. 17, 2025)(on file with Senate Appropriations Committee on Health and Human Services).
[18] Agency for Health Care Administration, *House Bill 1227 Bill Analysis* (Mar. 4, 2025)(on file with Senate Appropriations Committee on Health and Human Services.

**FOR CONSIDERATION By** the Appropriations Committee on Health and Human Services

603-03273A-25 20257032pb

A bill to be entitled

An act relating to Medicaid enrollment for permanently disabled individuals; amending s. 409.904, F.S.; requiring that certain persons who receive specified Medicaid-covered services and who are permanently disabled be presumed eligible for continued Medicaid coverage during redetermination processes; requiring the Agency for Health Care Administration to continue to make payments for such services; providing exceptions; requiring certain persons to notify the agency and the Department of Children and Families of certain changes in disability or economic status; authorizing the department to conduct a redetermination of eligibility under certain circumstances; requiring the department to make notifications under certain circumstances; defining the term "permanently disabled"; requiring the agency to seek federal authorization to exempt certain persons from annual redetermination of eligibility; requiring the agency and the department to develop a specified process; providing an effective date.

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

Section 1. Subsection (1) of section 409.904, Florida Statutes, is amended to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be







603-03273A-25 20257032pb

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)(a) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

(b)1. A person who was initially determined eligible for Medicaid under paragraph (a) and is receiving Medicaid-covered institutional care services, hospice services, or home and community-based services pursuant to s. 393.066 or s. 409.978, and who is permanently disabled, shall be presumed eligible for continued coverage for these Medicaid-covered services during any redetermination process, and the agency shall continue to make payments for such services, unless the person experiences a material change in his or her disability or economic status which results in a loss of eligibility. In the event of such a change in disability or economic status, the person or his or her designated caregiver or responsible party shall notify the agency and the Department of Children and Families of such change, and the Department of Children and Families may conduct a redetermination of eligibility. If such redetermination is

conducted, the Department of Children and Families must notify the person or his or her designated caregiver or responsible party before the commencement of the redetermination and, at its conclusion, the results of the redetermination.

2. As used in this paragraph, the term "permanently disabled" means that a person has been determined to be disabled under paragraph (a) and has had his or her qualifying disability or disabilities certified by a physician licensed under chapter 458 or chapter 459 as permanent in nature. The agency shall, no later than October 1, 2025, seek federal authorization to exempt a Medicaid-eligible permanently disabled person from annual redetermination of eligibility under the parameters of this paragraph.

3. The agency and the Department of Children and Families shall develop a process to facilitate the notifications required under subparagraph 1.

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

# 2025 AGENCY LEGISLATIVE BILL ANALYSIS
# Department of Children and Families

| BILL INFORMATION | |
|---|---|
| **BILL NUMBER:** | HB 1227 |
| **BILL TITLE:** | Medicaid Enrollment for Permanently Disabled Individuals |
| **BILL SPONSOR:** | Representative Tramont |
| **EFFECTIVE DATE:** | July 1, 2025 |

| COMMITTEES OF REFERENCE |
|---|
| **1)** House Health Care Facilities & Systems Subcommittee |
| **2)** House Health Care Budget Subcommittee |
| **3)** House Health & Human Services Committee |
| **4)** |
| **5)** |

| CURRENT COMMITTEE |
|---|
| |

| SIMILAR BILLS | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |

| PREVIOUS LEGISLATION | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |
| **YEAR:** | |
| **LAST ACTION:** | |

| IDENTICAL BILLS | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |

| Is this bill part of an agency package? |
|---|
| No. |

| BILL ANALYSIS INFORMATION | |
|---|---|
| **DATE OF ANALYSIS:** | For further information, please contact Sam Kerce at (850) 488-9410. |
| **LEAD AGENCY ANALYST:** | Tera Bivens, Office of Economic Self Sufficiency |
| **ADDITIONAL ANALYST(S):** | |
| **LEGAL ANALYST:** | Shawn Belcher, Office of General Counsel |
| **FISCAL ANALYST:** | Janetta Melton, Office of Budget |

# POLICY ANALYSIS

## 1. EXECUTIVE SUMMARY

House Bill 1227 directs the Agency for Healthcare Administration (AHCA) to seek federal approval to require Medicaid eligibility for permanently disabled individuals to be automatically renewed for five years. The bill also directs the Florida Department of Children and Families (Department) to collaborate with applicable state agencies to develop guidelines and process for determining disability.

## 2. SUBSTANTIVE BILL ANALYSIS

### 1. PRESENT SITUATION:

Medicaid provides medical coverage to low-income individuals and families. The state and federal government share the cost of the Medicaid program. Medicaid services in Florida are administered by AHCA. Medicaid eligibility in Florida is determined either by the Department or the Social Security Administration (SSA) (for SSI recipients). Since Medicaid is designed for low-income individuals, Medicaid eligibility is based on an evaluation of the individual's income and assets. Florida offers several Medicaid programs designed to support individuals with disabilities, including Medicaid for Aged and Disabled, Home and Community-Based Services Waivers, Medically Needy Program, and Program of All-Inclusive Care for the Elderly (PACE).

Section 1614(3) of the Social Security Act outlines that an individual shall be considered to be disabled for purposes of this title if they are unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months. Further, an individual under the age of 18 shall be considered disabled for the purposes of this title if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Florida's Medicaid State Plan provides the State's definition of permanent and total disability. A permanent impairment is a physical or mental condition of major significance which is expected to continue throughout the lifetime of an individual and is not expected to be removed or substantially improved by medical treatment. It is expected to continue for a prolonged period of disability and the eventual prognosis may be indefinite. Total disability exists when the permanent impairment or combination of permanent impairments substantially precludes the individual from engaging in a useful occupation. This includes gainful employment for which they have competence, or homemaking when the individual is maintaining a home for at least one person in addition to himself.

Disability is determined using the same criteria that the SSA uses to determine disability for benefits. If SSA determines an individual is disabled, the Department adopts their disability decision. If an individual does not have a disability decision from SSA, the Department must obtain a disability determination based on the individual's circumstances:

- For individuals residing at home in MEDS-AD (Aged and Disabled) and Medically Needy (Disabled) the Department utilizes the Department of Health-Division of Disability Determinations (DDD).
- For individuals requesting Institutional Care Program (ICP) or Home and Community Based-Services (HCBS) Waivers the Department utilizes the Department's disability medical review team.
    - For individuals receiving services through the Agency for Persons with Disabilities (APD) the Department accepts APD's disability decision.
        - Intermediate Care Facility Developmentally Disabled (ICF-DD)
        - iBudget Waiver

In accordance with federal requirements, Medicaid coverage is renewed every 12 months for recipients. During the renewal process the Department first attempts to automatically renew coverage by conducting an eligibility review based on reliable information available to the Department, without contacting or requiring information/response from the individual. If it is determined the individual still meets the eligibility requirements for Medicaid, the Department automatically renews the individual's coverage for an additional 12 months. This process is called an ex parte renewal. If the Department is unable to renew coverage automatically or through the ex parte process the individual's income and or assets could not be verified that they were under the eligibility standard, the Department sends a renewal notice. The renewal notice is sent electronically to the MyACCESS

Account and by mail based on the recipient's stated preference, for the individual or an authorized representative to provide the required information to make an eligibility determination. For individuals on a waiver coverage, the renewal notice is a two-page form that can be completed and uploaded in the customer portal, mailed, or faxed to the Department.

In March 2023, following the end of the Public Health Emergency (PHE), the federal government required states to reinstate the Medicaid redetermination process after not conducting redeterminations for almost three years. The Department conducted redeterminations from April 2023 through March 2024 for individuals whose coverage remained open during the PHE.

To assist this population with applying for and renewing their Medicaid, the Department provided health plans, providers, waiver support coordinators, and state agencies with direct system access. These groups are able to track these individuals in the system to monitor the current status and respective renewal dates, and receive notices and upload required documents to determine eligibility. Additionally, the Department provided these groups with individualized training on the system and an overview of their responsibilities and what is needed to assist this population to ensure continuous coverage is provided. Stakeholder engagement meetings have been created for these groups that serve this population to provide ongoing information to assist these families through the eligibility process.

**Categories of Medicaid that cover disabled populations**

**Family Related Medicaid (MAGI)**- The eligibility determination includes technical and financial factors including household size and income for the entire household, assets are not considered for eligibility. Although Medicaid eligibility considers the household's income, the eligibility determination is conducted at the individual level. Depending on the individual's coverage group, if the household's income thresholds are exceeded that individual would lose Medicaid coverage (income can be exceeded for parents but within the threshold for children, therefor children in the home would be eligible and the parents would not).

- From April 2023 through July 2024, 50,545 individuals with a disability determination received MAGI Family Related Medicaid coverage.
    - 45,987 Individuals maintained coverage
    - 4,558 Individuals lost coverage
        - 8.58% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 0.31% Failed to respond/provide requested information
        - 0.12% Deceased

- From April 2024 through February 2025, 37,175 individuals with a disability determination received MAGI Family Related Medicaid coverage.
    - 32,285 Individuals maintained coverage
    - 4,890 Individuals lost coverage
        - 11.88% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 1.05% Failed to respond/provide requested information
        - 0.22% Deceased

**Long Term Care (LTC) Medicaid (Non-MAGI)**- The eligibility determination includes technical and financial factors including household size, income for the entire household, and assets. The technical and financial requirements vary by program and depend on the type of coverage requested. The determination of eligibility is based on the type of coverage requested and the applicant meeting both technical and financial factors.

- From April 2023 through July 2024, 46,021 individuals with a disability determination received Non-MAGI LTC Medicaid coverage.
    - 43,220 Individuals maintained coverage
    - 2,801 Individuals lost coverage
        - 0.63% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 0.11% Failed to respond/provide requested information
        - 5.35% Deceased

- From April 2024 through February 2025, 45,577 individuals with a disability determination received Non-MAGI LTC Medicaid coverage.
    - 37,142 Individuals maintained coverage
    - 8,435 Individuals lost coverage
        - 3.79% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 0.61% Failed to respond/provide requested information
        - 14.11% Deceased

**Home and Community Based-Services (HCBS) Waivers Medicaid (Non-MAGI)**- For HCBS waiver groups, the recipient's financial eligibility is evaluated without regard to the income or assets of a spouse or parent. The eligibility determination is based on a household size of one (the individual) and income and assets for only that individual. If income and/or asset thresholds are exceeded, the individual would lose Medicaid coverage.

- From April 2023 through July 2024, 65,347 individuals with a disability determination received Non-MAGI HCBS Medicaid coverage.
    - 63,215 Individuals maintained coverage
    - 2,132 Individuals lost coverage
        - 0.56% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 0.09% Failed to respond/provide requested information
        - 2.61% Deceased

- From April 2024 through February 2025, 68,410 individuals with a disability determination received Non-MAGI HCBS Medicaid coverage.
    - 59,355 Individuals maintained coverage
    - 9,055 Individuals lost coverage
        - 5.10% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 0.73% Failed to respond/provide requested information
        - 7.41% Deceased

**Community Hospice Medicaid (Non-MAGI)**- The eligibility determination for Community Hospice is based on income and assets of the individual. Eligibility determination for Institutional Hospice is based on income and assets of the individual and the community spouse. Eligibility for Hospice regardless of where the individual is residing is typically 6 months or less due to the acuity of needs.

- From April 2023 through July 2024, 4,392 individuals with a disability determination received Non-MAGI Community Hospice Medicaid coverage.
    - 3,557 Individuals maintained coverage
    - 835 Individuals lost coverage
        - 1.43% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 0.11% Failed to respond/provide requested information
        - 17.46% Deceased

- From April 2024 through February 2025, 3,986 individuals with a disability determination received Non-MAGI Community Hospice Medicaid coverage.
    - 2,524 Individuals maintained coverage
    - 1,462 Individuals lost coverage
        - 7.58% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 1.08% Failed to respond/provide requested information
        - 28.02% Deceased

**Medicaid for Aged and Disabled (MEDS-AD) (Non-MAGI)** - MEDS-AD is Medicaid coverage for low-income individuals who are either aged (65 or older) or disabled. Eligibility for this group is based on technical requirements, income, and assets.

- From April 2023 through July 2024, 60,681 individuals with a disability determination received Non-MAGI MEDS-AD Medicaid coverage.
    - 56,746 Individuals maintained coverage
    - 3,935 Individuals lost coverage
        - 4.61% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 0.82% Failed to respond/provide requested information
        - 1.05% Deceased

- From April 2024 through February 2025, 45,746 individuals with a disability determination received Non-MAGI MEDS-AD Medicaid coverage.
    - 36,752 Individuals maintained coverage
    - 8,994 Individuals lost coverage
        - 14.19% Did not meet eligibility requirements (Income/Assets/FL Resident/etc)
        - 3.45% Failed to respond/provide requested information
        - 2.03% Deceased

If income requirements for the requested coverage type are exceeded the individual would lose Medicaid coverage but would be enrolled in the Medically Needy Program if the technical requirements are met. Currently, 441,815 individuals have a disability determination and are enrolled in the Medically Needy Program and also go through a redetermination every 12 months.

**2. EFFECT OF THE BILL:**

HB 1227 directs AHCA to seek a waiver from the Centers for Medicare and Medicaid Services (CMS) of 42 CFR 435.916 that requires Medicaid beneficiaries to be renewed every 12 months.

The bill would allow individuals who are permanently disabled to be renewed for Medicaid eligibility every 5 years instead of every 12 months. The bill defines permanent disability to include those who have a physical or intellectual disability that substantially limits 1 or more major life activities, has a history of an impairment, or is perceived by others as having an impairment.

Since Medicaid eligibility is determined at the individual level, other household members, that may not be included in the legislations intended population, will still be required to complete the renewal process annually, which would cause unnecessary confusion to the household. During the review of other household members, the Department may become aware of household circumstances that also impact the eligibility of the disabled individual. The Department would be federally required to take action based on any information received; however, the bill does not address whether the Department would act on that information and make a determination for all household members.

Medicaid recipients are required to inform the Department of any changes that may impact eligibility including income, assets, and household size. The Department is required to act on those changes which may include redetermining eligibility. HB 1227 provides a 5-year eligibility period; however, recipients would still be responsible for informing the Department of any reportable changes. Based on the information, eligibility may be redetermined and these individuals may lose coverage during their 5-year eligibility period.

Section 1917(c)(1)(A) of the Social Security Act provides that if an institutionalized or noninstitutionalized individual or the spouse of that individual disposes of assets for less than fair market value on or after a 60-month look-back period, the individual is ineligible Medicaid. The Department currently operationalizes this requirement by conducting the asset lookback at initial application, and since individuals complete a renewal every year, the lookback for renewals are conducted for 1 year during the renewal process.

During the PHE, households and individuals did not renew their Medicaid benefits for three years. This created issues with individuals not being familiar with the process, including responsibilities on their part to ensure their address is up to date, respond timely to requests, and provide all needed documents to conduct the redetermination. To mitigate this issue, the Department had a comprehensive outreach and marketing campaign to inform all participants of the upcoming renewals. Specifically for the Medicaid waiver program, this included presentations, trainings, and system access for providers, personalized direct outreach for Medicaid recipients and community meetings with sister agencies to provide direct support. While Medicaid Unwinding included a three-year period where recipients had not gone through an annual review, HB 1227 would result in a five-year period, which would create more opportunities for individual to be unaware of their responsibilities to renew.

**3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?**

| | |
|---|---|
| If yes, explain: | Yes |
| What is the expected impact to the agency's core mission? | |
| Rule(s) impacted (provide references to F.A.C., etc.): | 65A-1.701, 1.702, 1.710, 1.711, 1.712, 1.713, 1.7141, 7.16 |

**4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?**

| | |
|---|---|
| List any known proponents and opponents: | Unknown |
| Provide a summary of the proponents' and opponents' positions: | Unknown |

**5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?**

| | |
|---|---|
| If yes, provide a description: | No |
| Date Due: | N/A |
| Bill Section Number(s): | N/A |

**6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL?**

| | |
|---|---|
| Board: | N/A |
| Board Purpose: | N/A |
| Who Appoints: | N/A |
| Appointee Term: | N/A |
| Changes: | N/A |
| Bill Section Number(s): | N/A |

## FISCAL ANALYSIS

**1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?**

| | |
|---|---|
| Revenues: | N/A |
| Expenditures: | N/A |

| | |
|---|---|
| Does the legislation increase local taxes or fees? | N/A |
| If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase? | N/A |

**2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?**

| | |
|---|---|
| Revenues: | N/A |
| Expenditures: | Increased costs are anticipated as individuals would have a 5-year eligibility period without renewal, while (as noted above) several individuals may be determined ineligible for Medicaid due to income and assets. |
| Does the legislation contain a State Government appropriation? | No |
| If yes, was this appropriated last year? | N/A |

**3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?**

| | |
|---|---|
| Revenues: | N/A |
| Expenditures: | N/A |
| Other: | N/A |

**4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?**

| | |
|---|---|
| Does the bill increase taxes, fees or fines? | N/A |
| Does the bill decrease taxes, fees or fines? | N/A |
| What is the impact of the increase or decrease? | N/A |
| Bill Section Number: | N/A |

## TECHNOLOGY IMPACT

| | |
|---|---|
| Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)? | Yes |

| | |
|---|---|
| If yes, describe the anticipated impact to the agency including any fiscal impact. | The Department's ACCESS system would need enhancements to allow the system to provide 5 years of eligibility for individuals with disabilities. It is estimated to cost $708,000. |

## FEDERAL IMPACT

| | |
|---|---|
| Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)? | Yes |
| If yes, describe the anticipated impact including any fiscal impact. | The bill directs the Agency for Healthcare Administration to seek a waiver of 42 CFR 435.916 which requires an annual renewal of Medicaid beneficiaries.<br>The bill will require a State Plan amendment to include the bill's definition of permanent disability. |

## ADDITIONAL COMMENTS

- The bill does not define what Medicaid coverage types are included in the 5-year renewal period.
- The bill is unclear how the State would operationalize the definition of permanent disability, which allows the perception by others to determine whether an individual meets that definition.
- The bill is unclear who would be qualified to make a determination of permanent disability.
- The bill only directs the Department to collaborate with AHCA and APD but does not include the Department of Elder Affairs and Department of Health- Division of Disability Determinations (DDD).
- The bill creates a new definition of permanent disability that is not aligned with the State's Medicaid Plan or the Social Security Act.
- The bill is silent regarding requirements for individuals that would be required to report changes in income or assets that would impact Medicaid eligibility.
- The bill is silent regarding requirements relating to information obtained during the annual renewal for other household members that would require Department action.
- The bill does not address Medicaid eligibility determined by the Social Security Administration for individuals receiving Supplemental Security Income.

## LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

| | |
|---|---|
| Issues/concerns/comments and recommended action: | This bill would conflict with the requirement of 42 CFR 435.916(a) to renew all Medicaid beneficiaries every 12 months. |

# 2025 AGENCY LEGISLATIVE BILL ANALYSIS

## AGENCY: Agency for Health Care Administration

| BILL INFORMATION | |
|---|---|
| **BILL NUMBER:** | HB 1227 |
| **BILL TITLE:** | Medicaid Enrollment for Permanently Disabled Individuals |
| **BILL SPONSOR:** | Representative Tramont |
| **EFFECTIVE DATE:** | July 1 ,2025 |

| COMMITTEES OF REFERENCE |
|---|
| **1)** Health Care Facilities & Systems Subcommittee |
| **2)** Health Care Budget Subcommittee |
| **3)** Health & Human Services Committee |
| **4)** |
| **5)** |

| CURRENT COMMITTEE |
|---|
| Health Care Facilities & Systems Subcommittee |

N/A

| SIMILAR BILLS | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |

| PREVIOUS LEGISLATION | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |
| **YEAR:** | |

| IDENTICAL BILLS | |
|---|---|
| **BILL NUMBER:** | |
| **SPONSOR:** | |

| LAST ACTION: | |
|---|---|

| Is this bill part of an agency package? |
|---|
| Y ___ N _x__ |

| BILL ANALYSIS INFORMATION | |
|---|---|
| **DATE OF ANALYSIS:** | 3/4/2025 |
| **LEAD AGENCY ANALYST:** | Angela Pridgeon |
| **ADDITIONAL ANALYST(S):** | John Mattson |
| **LEGAL ANALYST:** | |
| **FISCAL ANALYST:** | Jeff Mistich, Bobby Jernigan |

## POLICY ANALYSIS

### 1. EXECUTIVE SUMMARY

House bill (HB) 1227 amends Section (s.) 409.902, Florida Statutes (F.S.) requiring the Agency for Health Care Administration (Agency) to seek federal approval to allow eligibility determinations for Medicaid and the Children's Health Insurance Program (CHIP) be completed every five years for Medicaid-qualified individuals who are permanently disabled. Enrollment will be continuous during this five year period, meaning in-between eligibility redeterminations every five years, permanently disabled individuals cannot be disenrolled from Medicaid for changes in income or assets reported to the Department of Children and Families (DCF).

The bill requires the Agency to submit the request for federal approval to implement the requirements in the bill by January 1, 2026. The bill also defines "permanent disability" and requires the Agency to collaborate with DCF and the Agency for Persons with Disabilities (APD) to adopt guidelines for determining whether an individual has a permanent disability.

HB 1227 has an operational impact on the Agency as the Agency would be required to seek federal authority through an 1115 waiver to waive requirements set forth in the federal Code of Federal Regulations (CFR), which may or may not be approved through the Centers for Medicare & Medicaid Services (CMS). The bill will also require the Agency to make procedural and system updates. These functions are part of the Agency's standard business practices and can be completed using existing Agency resources.

HB 1227 also has a fiscal impact on the Medicaid Program as all permanently disabled Medicaid recipients would be guaranteed Medicaid services for five years regardless of an increase in income or other changes in circumstances. The exact amount of the fiscal is indeterminate as it is unknown how many individuals will be eligible for the continuous five years of coverage based on the requirements of the bill. The cost of continuing to provide services to permanently disabled individuals eligible for continuous Medicaid coverage for five years, who would otherwise be ineligible, is also unknown.

HB 1227 may have both an operational and fiscal impact to DCF and APD as well as the Department of Health (DOH), who currently completes disability determinations for most Medicaid eligible recipients.

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

### 2. SUBSTANTIVE BILL ANALYSIS

#### 1. PRESENT SITUATION:

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. This authority includes establishing and maintaining a Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services (CMS). A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs; it establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. States set individual eligibility and service coverage criteria within federal minimum standards (with few exceptions). Together, the states and the federal government fund Medicaid.

In Florida, most Medicaid recipients receive their services through a managed care plan (Plan) contracted with the Agency under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and Dental. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in s. 409.973 and 409.98, F.S.

**Department of Children and Families (DCF)**
The Department of Children and Families (DCF) as the single state agency responsible for the

administration of social service funds under Title XX of the Social Security Act. In accordance with Section 409.902 F.S., DCF is also responsible for Medicaid eligibility determinations, including policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility.

**Agency for Persons with Disabilities (APD)**
The Agency for Persons with Disabilities (APD) is the single state agency that is tasked with serving the needs of Floridians with disabilities. APD is the operating agency for the Developmental Disabilities Individual Budgeting (iBudget) waiver, which is authorized through a 1915(c) Home and Community Based Services (HCBS) waiver. APD oversees enrollment in the waiver and the delivery of a wide range of social, medical, residential, and behavioral services that are based on coverage criteria and tailored to the individual's needs, as well determine clinical eligibility for the waiver.

**Florida Department of Health (DOH)**
The Florida Department of Health (DOH), Division of Disability Determinations is responsible for making the determination of medical eligibility for Florida citizens who apply for disability benefits under the federal Social Security Administration disability programs (Social Security Disability-Title II and Supplemental Security Income-Title XVI), and under the state Medically Needy program. It is also responsible for the periodic Continuing Disability Review (CDR) of all SSA disability beneficiaries to determine if they continue to meet medical eligibility criteria. SSI disability reviews occur every three years, and in the case of permanent disability, every five years.

**Medicaid Eligibility and Redeterminations**
DCF determines financial eligibility for Medicaid in compliance with the requirements specified in 42 CFR 435.916, which requires states to redetermine an individual's eligibility for Medicaid as least every 12 months. When determining eligibility for Medicaid coverage, an individual must meet all factors of eligibility to be eligible for coverage, including income and assets. Individuals eligible for Medicaid in Florida are:

- Parents and caretaker relatives of children
- Children (0-20 years of age)
- Pregnant women
- Individuals formerly in foster care (up to 26 years of age)
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving Supplemental Security Income (SSI)

42 CFR 435.916 states that the redetermination of eligibility must be made without DCF requiring information from the individual if DCF is able to make a determination based on reliable information contained in the individual's account or other more current information, including information through any databases accessed under 42 CFR 435.948, 42 CFR 435.949, and 42 CFR 435.956.

Additionally, 42 CFR 435.919, requires individuals eligible for Medicaid to report changes in circumstances, including changes in income or assets, to DCF when circumstances change in between their regular annual redetermination of eligibility. In Medicaid, continuous eligibility refers to the ability of a Medicaid eligible recipient to have guaranteed continuous Medicaid coverage for a set period of time regardless of changes in circumstance as described in 42 CFR 435.919. Federal law requires all states to provide children with 12 months of continuous Medicaid coverage. Although there is no equivalent federal continuous eligibility requirement for adults, states may choose to apply with CMS to provide continuous eligibility for adults through an 1115 Medicaid waiver.

**1915(c) Home and Community-Based Services Waivers**
Within broad federal guidelines, states can develop Home and Community-Based Services (HCBS) waivers to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting. In Florida, there are currently five approved HCBS waivers:

1. LTC Waiver
2. Developmental Disabilities Individual Budgeting (iBudget) Waiver
3. Model Waiver
4. Familial Dysautonomia (FD) Waiver

5. Comprehensive Intellectual and Developmental Disabilities (CIDD) Managed Care Pilot Program Waiver

A significant number of individuals who may be considered permanently disabled are receiving services through the LTC and iBudget Waivers. As of January 2025, there were 96,760 individuals enrolled in the LTC Waiver, and 37,148 individuals enrolled in the iBudget Waiver. The Model, FD, and CIDD Waivers have lower enrollment, with total enrollment totaling less than 300 across all three waivers as of January 2025.

All 1915(c) HCBS waivers include clinical level of care requirements, referenced in 42 CFR 441.301(b)(1)(iii), which specify individuals must meet a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care to be eligible for HCBS waiver services.

Within 42 CFR 441.302(c), requirements specify that there must be an initial evaluation to determine clinical level of care and reevaluations must occur at least annually. The Department of Elder Affairs assesses clinical level of care for the LTC and FD Waivers. The Children's Multidisciplinary Assessment Team assesses clinical level of care for the Model Waiver, and APD assesses clinical level of care for the iBudget and CIDD Waivers.

**1115 Research and Demonstration Waivers**
Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs. In Florida, there are two approved 1115 waivers: Managed Medical Assistance and Family Planning.

**2. EFFECT OF THE BILL:**

HB 1227 amends s. 409.902, F.S., requiring the Agency to establish automatic and continuous enrollment for five years for Medicaid-eligible recipients that qualify as permanently disabled, and requires the Agency to seek federal approval to implement the requirements of the bill by January 1, 2026.

The bill also defines "permanent disability" and requires the Agency to collaborate with the DCF and APD to adopt guidelines for determining wither an individual has a permanent disability. HB 1227 does not reference DOH, who is the primary agency in Florida for disability determinations.

The requirements of HB 1227 may conflict with federal regulations and Florida Statute regarding eligibility renewal requirements. 42 CFR 435.916, Regularly scheduled renewals of Medicaid eligibility, requires eligibility to be renewed once every 12 months. The state may or may not be able to waive these federal requirements through an 1115 waiver. HB 1227 requires Medicaid enrollment to be automatic and continuous for five years. Additionally, 42 CFR 441.301 and 441.302 outline the level of care requirements for individuals receiving HCBS waiver services, requiring annual redeterminations. Furthermore, s. 409.818(1)(b), F.S., establishes the eligibility period for children under the age of five providing coverage for 12 months without redetermination or reverification of eligibility. Without a similar update to statute, this population could be excluded from the changes to 409.902, F.S.

42 CFR 435.919, Changes in circumstances, requires Medicaid recipients to report changes in circumstances to DCF outside of the regular redetermination process. Guaranteeing continuous coverage for five years regardless of a change in circumstances as directed in the bill may have unintended consequences for families eligible for the continuous five-year coverage. Although a Medicaid recipient would still be required to report a change in circumstances to DCF in accordance with federal law, unless a Medicaid recipient proactively contacts DCF, DCF may not know of a change in circumstance, such as an address or name change. Completing an annual eligibility redetermination allows DCF to review any information and make any updates necessary to ensure they receive all of their public benefits. If a recipient is guaranteed coverage for five years, there may not be an incentive for them to update their information when something changes, which could unintentionally, negatively impact access to their public benefits.

**Operational Impact**

The Agency would be required to seek federal authority through an 1115 research and demonstration waiver to waive the requirements outlined in 42 CFR 435.916, 42 CFR 441.301, and 42 CFR 441.302. It is unclear whether this waiver would be allowable or approvable by CMS. The Agency has been unable to locate any states that have received approval for an 1115 Waiver waiving similar federal requirements for adults or the disabled population. However, a few states have received 1115 Waiver approval to extend continuous eligibility for children past the required 12 months. Submitting an 1115 Waiver application is standard business practice for the Agency and can be accomplished using existing resources. The timeline of CMS approval for 1115 demonstrations can vary greatly and could take anywhere from six months to three years.

The Agency would most likely need to make programming changes to the Florida Medicaid Management Information System (FMMIS) to allow for the additional continuous eligibility period. Most system updates can be accomplished within three to six months, but this is dependent upon the complexity of the task(s). This change can also be accomplished using existing Agency resources.

Lastly, the bill requires the Agency to collaborate with DCF and APD to adopt guidelines and procedures for determining whether an individual has a permanent disability. However, there are Medicaid recipients that may qualify as permanently disabled that are not receiving services through the APD waiver such as persons with disabilities who are enrolled in Medicaid's LTC program and residing in skilled nursing facilities, or those enrolled in regular Medicaid but determined disabled by DOH. HB 1227 does not address this population and will require the Agency to create a process to identify permanently disabled persons across all current eligibility groups that include individuals who meet the definition of permanently disabled as outlined in the bill.

As DCF determines financial eligibility for the Medicaid program, HB 1227 may have both an operational and fiscal impact on DCF. Additionally, HB 1227 may also have operational and fiscal impacts on APD. Though not referenced in the bill, HB 1227 is likely to have operational and fiscal impacts on DOH as well. HB 1227 defines permanently disabled and requires the Agency, DCF, and APD to adopt guidelines and procedures for determining permanent disabilities, which at present falls under the purview of DOH. Additionally, HB 1227 may also have operational and fiscal impacts on APD if they are to begin completing all disability determinations for Medicaid.

**Fiscal Impact**

HB 1227 has a fiscal impact on the Medicaid Program as all permanently disabled Medicaid recipients would be guaranteed Medicaid services for five years regardless of an increase in income or other changes in circumstances. The exact amount of the fiscal is indeterminate as it is unknown how many individuals will be eligible for the continuous five years of coverage based on the requirements of the bill. The cost of continuing to provide services to permanently disabled individuals eligible for continuous Medicaid coverage for five years, who would otherwise be ineligible, is also unknown.

**3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?** Y _x__ N ___

| | |
|---|---|
| If yes, explain: | |
| Is the change consistent with the agency's core mission? | Y ___ N _X__ |
| Rule(s) impacted (provide references to F.A.C., etc.): | |

**4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?**

| | |
|---|---|
| Proponents and summary of position: | |
| Opponents and summary of position: | |

**5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?** Y ___ N _X__

| | |
|---|---|
| If yes, provide a description: | |
| Date Due: | |
| Bill Section Number(s): | |

**6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQUIRED BY THIS BILL?** Y ___ N X____

| | |
|---|---|
| Board: | |
| Board Purpose: | |
| Who Appointments: | |
| Appointee Term: | |
| Changes: | |
| Bill Section Number(s): | |

## FISCAL ANALYSIS

**1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT?** Y ___ N __X_

| | |
|---|---|
| Revenues: | |
| Expenditures: | |
| Does the legislation increase local taxes or fees? If yes, explain. | |
| If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase? | |

**2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT?** Y ___ N __X_

| | |
|---|---|
| Revenues: | |
| Expenditures: | As written, HB 1227 will not have a fiscal impact to the Medicaid budget. |
| Does the legislation contain a State Government appropriation? | |
| If yes, was this appropriated last year? | |

**3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR?** Y ___ N _X__

| | |
|---|---|
| Revenues: | |
| Expenditures: | |

| | |
|---|---|
| Other: | |

**4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?** Y ___ N _X___

| | |
|---|---|
| If yes, explain impact. | |
| Bill Section Number: | |

## TECHNOLOGY IMPACT

**1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)?** Y ___ N __X_

| | |
|---|---|
| If yes, describe the anticipated impact to the agency including any fiscal impact. | |

## FEDERAL IMPACT

**1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)?** Y ___ N __X_

| | |
|---|---|
| If yes, describe the anticipated impact including any fiscal impact. | |

## ADDITIONAL COMMENTS

| |
|---|
| |

## LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

| | |
|---|---|
| Issues/concerns/comments: | |

The Florida Senate

# APPEARANCE RECORD

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

4/10/2025
Meeting Date

HHS
Committee

SB 7032
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dina Justice, COO, The Arc of Florida Phone

Address 2898 Mahan Dr Stel Email dina@arcflorida.org
Street

TLH 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: The Arc of Florida

☐ 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 306 |
| INTRODUCER: | Health Policy Committee and Senator Sharief and others |
| SUBJECT: | Medicaid Providers |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Morgan | Brown | HP | **Fav/CS** |
| 2. | Barr | McKnight | AHS | **Favorable** |
| 3. | | | FP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 306 requires the Agency for Health Care Administration to establish specific standards to ensure Florida Medicaid enrollees have access to network providers during state holidays and outside regular business hours.

The bill has no fiscal impact on state expenditures or revenues. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

### Agency for Health Care Administration

The 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] 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 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;
- Transportation to medical 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] 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] 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] Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[9] *Id*.
[10] Agency for Health Care Administration, *Senate Bill 1060* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[11] *Supra* note 8.

- 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 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 managed care 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 nonparticipating providers.[15] If the managed care plan declines to include individual or group

[12] Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[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).
[15] 42 C.F.R. § 438.206(b)(4)

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, SMMC 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]

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]

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[16] 42 C.F.R. § 438.12(a)(1)
[17] Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[18] 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 17.
[20] *Supra* note 18, Page 234 of 267.
[21] *Supra* note 18, Page 201 of 267.
[22] *Supra* note 17.
[23] 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] *Id.*, Pages 70-72.
[25] 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).

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:

**Section 1** amends s. 409.967, F.S., to require the Agency for Health Care Administration 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 Medicaid managed care plan provider network must offer appointment availability to Medicaid enrollees outside regular business hours.

The bill also 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.

**Section 2** provides that the bill takes effect 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.

[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.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

This bill has no fiscal impact on state expenditures or revenues.

## 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 Agency for Health Care Administration 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.

**By** the Committee on Health Policy; and Senators Sharief, Gaetz, and Davis

588-03163-25 2025306c1

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.

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 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 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 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.

The Florida Senate

# Committee Agenda Request

**To:** Senator Jay Trumbull, Chair
Appropriations Committee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** April 1, 2025

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I respectfully request that **Senate Bill # 306**, relating to Manage 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)

**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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 524 |
| INTRODUCER: | Appropriations Committee on Health and Human Services and Senator Harrell |
| SUBJECT: | Newborn Screenings |
| DATE: | April 14, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Morgan | Brown | HP | **Favorable** |
| 2. | Gerbrandt | McKnight | AHS | **Fav/CS** |
| 3. | | | FP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 524 amends s. 383.14, F.S., to require the Florida Department of Health (DOH) to revise its newborn screening rules to require the screening of newborns for Duchenne muscular dystrophy at the appropriate age, beginning January 1, 2027.

The bill has a significant negative fiscal impact on state expenditures. However, the bill is subject to legislative appropriation. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

### Newborn Screening

Newborn screening (NBS) is a preventive public health program provided in every state to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death. The federal government produces a standardized list of conditions that it recommends every newborn be

screened for, but each state determines which conditions and screenings to include in its own NBS program.[1]

***Federal Recommendations for NBS***

The U.S. Department of Health and Human Services (HHS) Advisory Committee on Heritable Disorders in Newborns and Children (Advisory Committee) was established to reduce morbidity and mortality in newborns and children who have, or are at risk for, heritable disorders. The Advisory Committee advises the Secretary of HHS on the most appropriate application of universal NBS tests, technologies, policies, guidelines, and standards.[2]

The federal Recommended Uniform Screening Panel (RUSP) is a list of disorders recommended by the Secretary of HHS, based on advice from the Advisory Committee, for states to screen as part of their NBS program. The inclusion of a disorder in the RUSP is determined based on evidence supporting the potential net benefit of screening, the ability of states to screen for the disorder, and the availability of effective treatments. Adding a condition to the RUSP usually takes three to four years; it is a multistep process beginning with the submission of a nomination package for review by the Advisory Committee, which might or might not result in a recommendation to include the condition in the RUSP. Anyone can nominate a condition for inclusion by completing a nomination package. The RUSP currently includes screening for 36 core conditions and 26 secondary conditions.

Duchenne muscular dystrophy has been nominated for inclusion in the RUSP but has not been recommended by Advisory Committee.[3]

***The Florida NBS Program***

The Florida NBS Program (NBS Program) was initially established in 1965 to screen newborns for a single condition, phenylketonuria.[4] The NBS Program has since evolved to screen for a wide range of congenital conditions. The NBS program is housed within the Department of Health (DOH) and serves to promote the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.[5]

The NBS Program attempts to screen all newborns to identify, diagnose, and manage newborns at risk for select disorders that, without detection and treatment, can lead to permanent

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[1] Health Resources & Services Administration, Advisory Committee on Heritable Disorders in Newborns and Children, *History of the ACHDNC, available at* https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/hrsa-timeline-interactive.pdf (last visited Mar. 22, 2025).

[2] Health Resources & Services Administration, *Advisory Committee on Heritable Disorders in Newborns and Children, available at* https://www.hrsa.gov/advisory-committees/heritable-disorders (last visited Mar. 22, 2025).

[3] *Id*.

[4] *See*, Tatiana Wing, R.C. Philips Research and Education Unit, *Newborn Screening Update* (2020), *available at* https://genetics.pediatrics.med.ufl.edu/wordpress/files/2019/11/RCPU-Newborn-screening-update.pdf (last visited Mar. 22, 2025); Watson, S., Lloyd-Puryear, M., & Howell, R. (2022), *The Progress and Future of US Newborn Screening*, International Journal of Neonatal Screening, 8:41, *available at* https://doi.org/10.3390/ijns8030041 (last visited Mar. 22, 2025). Phenylketonuria (PKU) is a rare inherited disorder that causes an amino acid called phenylalanine to build up in the body resulting in dangerous symptoms unless a specific diet is adhered to. PKU was the first inheritable condition for which a relatively simple and repeatable blood test was able to be conducted at a high enough throughput to enable population-level screening.

[5] Section 383.14, F.S.

developmental and physical damage or death.[6] Parents and guardians may decline the screenings.[7]

The Florida Genetics and Newborn Screening Advisory Council (GNSAC) advises the DOH on disorders to be included in Florida's panel of screened disorders and the procedures for collecting and transmitting specimens.[8] The Florida NBS Program currently screens for 37 core conditions and 23 secondary conditions, nearly all of which are screened through the collection and testing of blood spots. Hearing screening, critical congenital heart disease, and targeted testing for congenital cytomegalovirus are completed at the birthing facility through point of care (POC) testing.[9]

Under current law, when a new condition is added to the federal RUSP, the GNSAC is required to consider the condition and make a recommendation to the DOH as to whether the condition should be included in the state NBS panel within one year.[10] GNSAC reviews the recommendations to ensure:[11]

- The state's readiness to screen, diagnose, and treat the condition;
- The condition is known to result in significant impairment in health, intellect, or functional ability if not treated before clinical signs appear;
- The condition can be detected using screening methods accepted by current medical practice;
- The condition can be detected prior to the infant becoming two weeks of age, or at the appropriate age as indicated by accepted medical practice;
- After screening for the disorder, reasonable cost benefits can be anticipated through a comparison of tangible program costs with those medical, institutional, and special educational costs likely to be incurred by an undetected population; and
- When screening for a condition, sufficient pediatric medical infrastructure is available.

The Florida NBS Program involves coordination across several entities, including the Bureau of Public Health Laboratories Newborn Screening Laboratory (state laboratory), the DOH's Children's Medical Services Newborn Screening (CMS NBS) Follow-up Program, referral centers, birthing centers, and physicians throughout the state. Health care providers in hospitals, birthing centers, perinatal centers, county health departments, and school health programs provide screening as part of the multilevel NBS Program screening process.[12]

Health care providers in hospitals and birthing centers collect drops of blood from the newborn's heel on a standardized specimen collection card, which is then sent to the state laboratory for testing.[13] POC testing is used at the birthing facility to screen for the conditions which cannot be

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[6] Florida Department of Health, *Florida Newborn Screening 2022 Protocols* (Mar. 15, 2022), *available at* https://floridanewbornscreening.com/wp-content/uploads/NBS-Protocols-2022-FINAL.pdf (last visited Mar. 22, 2025).
[7] Section 383.14, F.S.; Rule 64C-7.008, F.A.C. The health care provider must attempt to get a written statement of objection to be placed in the medical record.
[8] Section 383.14, F.S.
[9] Florida Department of Health, *2025 Agency Legislative Bill Analysis, HB 1089* (Mar. 12, 2025) (on file with the Senate Committee on Health Policy).
[10] *Supra* note 9.
[11] *Supra* note 10.
[12] *Supra* note 9.
[13] Florida Department of Health, Florida Newborn Screening Program, *What is Newborn Screening?, available at* https://floridanewbornscreening.com/parents/what-isnewborn-screening/ (last visited Mar. 22, 2025). *See also,* Florida

screened for with blood spot testing such as. pulse oximetry tests for critical congenital heart defect and hearing screening to detect hearing loss.[14]

Screening results are released to the newborn's health care provider and in the event of an abnormal result, the baby's health care provider, or a nurse or specialist from the CMS NBS Follow-up Program, provides follow-up services and referrals for the child and his or her family.[15]

The DOH is authorized to charge and collect a fee not to exceed $15 per live birth occurring in a hospital or birth center to administer the NBS Program. The DOH must calculate the annual assessment for each hospital and birth center and then quarterly generate and mail each hospital and birth center a statement of the amount due. The DOH bills hospitals and birth centers quarterly using vital statistics data to determine the amount to be billed. The DOH is authorized to bill third-party payers for the screening tests and bills insurers directly for the cost of the screening.[16] The DOH does not bill families that do not have insurance coverage.[17]

**Duchenne Muscular Dystrophy**

Duchenne muscular dystrophy (DMD), the most common form of muscular dystrophy, is a condition that causes skeletal and heart muscle weakness that quickly gets worse with time. Symptoms usually begin by the age of six years, and the condition mainly affects boys. Currently, no cure exists, so treatment involves managing symptoms and improving quality of life.[18]

DMD is caused by a change or mutation in the gene that gives instructions for a protein called dystrophin. Dystrophin is a critical part of the dystrophin-glycoprotein complex (DGC), which plays an important role as a structural unit of muscle. In DMD, both dystrophin and DGC proteins are missing, which ultimately leads to the death (necrosis) of muscle cells. People with DMD have less than five percent of the normal quantity of dystrophin needed for healthy muscles.[19]

As an individual with DMD becomes older, the individual's muscles cannot replace the dead cells with new ones, and connective and adipose (fat) tissue gradually replaces muscle fibers.[20]

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Department of Health, Florida Newborn Screening, *Specimen Collection Card*, *available at* http://floridanewbornscreening.com/wp-content/uploads/Order-Form.png (last visited Mar. 22, 2025).

[14] Florida Department of Health, *2024 Agency Legislative Bill Analysis, HB 499* (Feb. 7, 2024) (on file with the Senate Committee on Health Policy).

[15] *Id*.

[16] Section 383.145, F.S.

[17] Section 383.14, F.S.

[18] Cleveland Clinic, *Duchenne Muscular Dystrophy (DMD)*, *available at* https://my.clevelandclinic.org/health/diseases/23538-duchenne-muscular-dystrophy-dmd#symptoms-and-causes (last visited Mar. 22, 2025).

[19] *Id*.

[20] *Id*.

***DMD Symptoms***

Symptoms of DMD most often appear between the ages of two and four years, though symptoms can present as early as infancy or be noticed later in childhood. DMD causes muscle weakness that progressively worsens, so common symptoms include:[21]

- Progressive muscle weakness and atrophy (loss of muscle bulk) beginning in the child's legs and pelvis.
- Calf muscle hypertrophy (increase in muscle size).
- Difficulty climbing up stairs.
- Difficulty walking that becomes progressively worse.
- Frequent falls.
- Waddling gait.
- Toe walking.
- Fatigue.
- Cardiomyopathy (disease of the heart muscle).
- Breathing difficulties and shortness of breath.
- Cognitive impairment.
- Delayed speech and language development.
- Developmental delay.
- Scoliosis (spine curvature).
- Short stature (height).

DMD affects approximately one in 3,600 male live-born infants. About 2.5 to 20 percent of girls who are DMD carriers may have symptoms that are milder than the typical case.[22]

***DMD Diagnosis and Testing***

A health care provider will likely perform a physical, neurological, and muscle exam on a child experiencing symptoms of DMD, asking detailed questions related to symptoms and medical history, and order the following tests:[23]

- Creatine Kinase (CK) Blood Test – The muscles release CK when damaged, so elevated levels may indicate DMD. Levels typically peak by age two and can be more than 10 to 20 times above the normal range.
- Genetic Blood Test – A genetic blood test looking for a complete or near-complete absence of the dystrophin gene can confirm the diagnosis of DMD.
- Muscle Biopsy – A child's provider may take a small sample of muscle tissue from a muscle in the child's thigh or calf. A specialist will review the sample under a microscope to look for signs of DMD.

[21] *Id*.
[22] Cleveland Clinic, *Duchenne Muscular Dystrophy (DMD), available at* https://my.clevelandclinic.org/health/diseases/23538-duchenne-muscular-dystrophy-dmd#symptoms-and-causes (last visited Mar. 22, 2025).
[23] Cleveland Clinic, *Duchenne Muscular Dystrophy (DMD), available at* https://my.clevelandclinic.org/health/diseases/23538-duchenne-muscular-dystrophy-dmd#symptoms-and-causes (last visited Mar. 22, 2025).

- Electrocardiogram (EKG) – As DMD almost always affects the heart, a child's provider will likely perform an EKG to look for characteristic signs of DMD and to check the health of the child's heart.

***DMD Management and Treatment***

Currently, there is no cure for DMD, so the main goal of treatment is to manage symptoms and improve quality of life. Supportive therapies for DMD include:[24]

- Corticosteroids – Corticosteroids, such as prednisolone and deflazacort, are beneficial for delaying muscle strength loss, improving lung function, delaying scoliosis, slowing the progression of cardiomyopathy and prolonging survival.
- Medication to Treat Cardiomyopathy – Early treatment with angiotensin-converting enzyme (ACE) inhibitors and/or beta-blockers may slow the progression of cardiomyopathy and prevent the onset of heart failure.
- Physical Therapy – The main goal of physical therapy for DMD is to prevent contractures, permanent tightening of the muscles, tendons and skin. This usually involves certain stretching exercises.
- Surgery to Help Treat Scoliosis and Contractures – Surgery to release contractures may be necessary for severe cases. Surgery to correct scoliosis may improve lung and breathing function.
- Exercise – A child's health care provider will likely recommend gentle exercise to avoid muscle atrophy due to lack of use. This is usually a combination of swimming and recreation-based exercises.
- Mobility Aids – Braces, canes, wheelchairs, etc.
- Tracheostomy and Assisted Ventilation for Respiratory Failure.

With improvement in supportive care, the life expectancy of DMD has significantly improved over the past few decades. There are also many new drugs currently undergoing clinical testing that show promise in treating DMD. Some newer treatments employing "exon skipping" (patching over a missing or mutated part of the dystrophin gene) have recently received federal Food and Drug Administration (FDA)[25] approval. These treatments are applicable only to a minority of cases with specific mutations. Although these treatments increase dystrophin protein amount in muscle, meaningful gain in strength and physical function has not yet been shown.[26]

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[24] *Id*.

[25] The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA also provides accurate, science-based health information to the public. USAGov, *Food and Drug Administration (FDA),* available at https://www.usa.gov/agencies/food-and-drug-administration#:~:text=The%20Food%20and%20Drug%20Administration,and%20products%20that%20emit%20radiation. (last visited Mar. 22, 2025).

[26] Cleveland Clinic, *Duchenne Muscular Dystrophy (DMD), available at* https://my.clevelandclinic.org/health/diseases/23538-duchenne-muscular-dystrophy-dmd#symptoms-and-causes (last visited Mar. 22, 2025).

***DMD Prevention and NBS***

As DMD is an inherited condition, there is no prevention and about a third of cases occur randomly without a family history of the condition.[27] Genetic counseling is an option that exists to provide information to concerned families about how genetic conditions affect the family, determining the risk for developing or passing on certain conditions.[28] In some situations, prenatal testing may be able to diagnose DMD in early pregnancy.[29]

Newborn screening has been proposed as a method for ensuring early diagnosis of DMD. Advocates for NBS for DMD point to evidence suggesting that emerging DMD therapies might prove to be most effective if initiated before the onset of symptoms.[30,31] Furthermore, delayed diagnosis of DMD leads to lost opportunities for genetic counseling, implementation of appropriate standards of care, access to newly approved disease-modifying medications, and participation in clinical trials. However, there are ethical, legal, and social concerns related to the development and implementation of newborn screening for DMD. These concerns include the limited treatment options available, whether both males and females should be screened, and the high rate of false-positives resulting from the first-tier diagnostic test.[32]

Newborn screening for DMD has been adopted in several states; it has been implemented in Minnesota and Ohio, and New York and Massachusetts are in the planning phases.[33] The method of screening is similar to the conventional diagnostic method for suspected cases of DMD. A blood spot test is conducted to measure CK levels, followed by a confirmatory genetic test. One of the primary concerns with this screening method is the relatively high frequency of elevated CK levels in newborns that are unrelated to DMD, leading to false positives and unnecessary genetic testing.[34]

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[27] *Id*.
[28] Cleveland Clinic, *Genetic Counseling*, *available at* https://my.clevelandclinic.org/health/articles/23086-genetic-counseling (last visited Mar. 22, 2025).
[29] *Supra* note 30.
[30] Birnkrant, D. J., Bushby, K., Bann, C. M., Apkon, S. D., Blackwell, A., Brumbaugh, D., Case, L. E., Clemens, P. R., Hadjiyannakis, S., Pandya, S., Street, N., Tomezsko, J., Wagner, K. R., Ward, L. M., Weber, D. R., & DMD Care Considerations Working Group (2018), *Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management*, The Lancet, Neurology, 17(3), 251–267, *available at* https://doi.org/10.1016/S1474-4422(18)30024-3 (last visited Mar. 22, 2025).
[31] Parent Project Muscular Dystrophy, *Newborn Screening Action Center*, *available at* https://www.parentprojectmd.org/advocacy/newborn-screening-action-center/ (last visited Mar. 22, 2025).
[32] Thomas, S., Conway, K. M., Fapo, O., Street, N., Mathews, K. D., Mann, J. R., Romitti, P. A., Soim, A., Westfield, C., Fox, D. J., Ciafaloni, E., & Muscular Dystrophy Surveillance, Tracking, and Research Network (MD STARnet) (2022), *Time to diagnosis of Duchenne muscular dystrophy remains unchanged: Findings from the Muscular Dystrophy Surveillance, Tracking, and Research Network*, 2000-2015, Muscle & nerve, 66(2), 193–197, *available at* https://doi.org/10.1002/mus.27532 (last visited Mar. 22, 2025).
[33] *Supra* note 35.
[34] *Birnkrant, D. J., Bushby, K., Bann, C. M., Apkon, S. D., Blackwell, A., Brumbaugh, D., Case, L. E., Clemens, P. R., Hadjiyannakis, S., Pandya, S., Street, N., Tomezsko, J., Wagner, K. R., Ward, L. M., Weber, D. R., & DMD Care Considerations Working Group (2018), Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management, The Lancet, Neurology, 17(3), 251–267, available at https://doi.org/10.1016/S1474-4422(18)30024-3 (last visited Mar. 22, 2025).*

**RUSP Nomination Not Approved**

DMD was nominated for inclusion in the RUSP by the Parent Project Muscular Dystrophy[35] and the Muscular Dystrophy Association.[36] The process began in February 2023, but a pause in the review process was requested by the nominators after the Advisory Committee determined there was insufficient evidence to move forward and requested additional information regarding the diagnostic process and clinical utility.[37] The RUSP is largely restricted to neonatal-onset disorders for which early treatment shows improved outcome. DMD differs from the majority of conditions included on the RUSP because onset does not occur until later in childhood.[38]

## III. Effect of Proposed Changes:

The bill amends s. 383.14, F.S., to require, subject to legislative appropriation, the Department of Health (DOH) to adopt and enforce rules requiring every newborn in the state to be screened for Duchenne Muscular Dystrophy (DMD) at the appropriate age, beginning January 1, 2027.

The bill takes effect 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.

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[35] Parent Project Muscular Dystrophy, *available at* https://www.parentprojectmd.org/ (last visited Mar. 22, 2025).
[36] Muscular Dystrophy Association, *available at* https://www.mda.org/ (last visited Mar. 2, 2025).
[37] U.S. Department of Health and Human Services, *Advisory Committee on Heritable Disorders in Newborns and Children, Chair Letter to DMD Nominators* (2023), *available at* https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritabledisorders/resources/chair-letter-dmd-nominators.pdf (last visited Mar. 22, 2025); Health Resources & Services Administration, *Summary of Nominated Conditions to the Recommended Uniform Screening Panel* (2024), available at https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/rusp/summary-nominated-conditions.pdf (last visited Mar. 22, 2025).
[38] *Supra* note 38.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill is subject to legislative appropriation. The Department of Health estimates a total cost of $2.7 million to implement the provisions of the bill:

- Three laboratory personnel - $272,202 recurring.
- Laboratory Testing Supplies - $984,000 recurring.
- Information Technology Updates - $75,000 nonrecurring.
- Expense - $81,532 ($57,784 recurring, $23,748 nonrecurring).
- Registered Nurse Consultant - $117,759 recurring.
- Specialty Care for Out-of-Range Results - $1,148,469 recurring:
  - Geneticist – 0.5 FTE
  - Genetics Counseling – 1 FTE
  - Dietician – 0.5 FTE
  - Social Worker – 0.5 FTE.[39]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 383.14 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 Appropriations Committee on Health and Human Services on April 10, 2025:**
The committee substitute provides that the bill is subject to legislative appropriation.

[39] Florida Department of Health, 2025 Agency Legislative Bill Analysis, HB 1089 (Mar. 12, 2025) (on file with the Senate Committee on Health Policy).

B. Amendments:

None.

342978

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/10/2025 | . | |
| | . | |
| | . | |
| | . | |

The Appropriations Committee on Health and Human Services (Harrell) recommended the following:

**Senate Amendment (with title amendment)**

Delete line 38

and insert:

department may deem necessary. Subject to legislative appropriation, beginning January 1, 2027, the

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

And the title is amended as follows:

Delete line 3

342978

and insert:

383.14, F.S.; subject to legislative appropriation and beginning on a specified date, requiring

**By** Senator Harrell

31-00466-25 2025524__

A bill to be entitled

An act relating to newborn screenings; amending s. 383.14, F.S.; beginning on a specified date, requiring that the Department of Health's rules require that newborns be screened for Duchenne muscular dystrophy at the appropriate age; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) of section 383.14, Florida Statutes, is amended to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(2) RULES.—

(a) After consultation with the Genetics and Newborn Screening Advisory Council, the department shall adopt and enforce rules requiring that every newborn in this state shall:

1. Before becoming 1 week of age, have a blood specimen collected for newborn screenings;

2. Be tested for any condition included on the federal Recommended Uniform Screening Panel which the council advises the department should be included under the state's screening program. After the council recommends that a condition be included, the department shall submit a legislative budget request to seek an appropriation to add testing of the condition to the newborn screening program. The department shall expand statewide screening of newborns to include screening for such conditions within 18 months after the council renders such advice, if a test approved by the United States Food and Drug







31-00466-25 2025524__

Administration or a test offered by an alternative vendor is available. If such a test is not available within 18 months after the council makes its recommendation, the department shall implement such screening as soon as a test offered by the United States Food and Drug Administration or by an alternative vendor is available; and

3. At the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary. Beginning January 1, 2027, the rules must require that newborns be screened for Duchenne muscular dystrophy at the appropriate age.

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

# 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

April 3, 2025

Senator Trumbull
415 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 264 – Step-Therapy Protocols be placed on the next available agenda for the Health and Human Services Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, 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**

**THE FLORIDA SENATE**

Tallahassee, Florida 32399-1100

**SENATOR GAYLE HARRELL**
31st District

**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

April 3, 2025

Senator Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumble,

I respectfully request that SB 524 –New Born Screening be placed on the next available agenda for the Health and Human Services Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

**THE FLORIDA SENATE**

Tallahassee, Florida 32399-1100

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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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1156 –Home Health Aide for Medically Fragile Children be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
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**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

**THE FLORIDA SENATE**

Tallahassee, Florida 32399-1100

**COMMITTEES:**
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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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1182 –Medicaid Coverage of Continuous Glucose Monitors be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
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Senate's Website: *www.flsenate.gov*

**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

**THE FLORIDA SENATE**

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Appropriations Committee on Higher Education, *Chair*
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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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1490 –Childrens Medical Services Program be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, 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

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**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1602 –Health Care Patient Protection be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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# APPEARANCE RECORD

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|---|---|
| 4/10/25 | 524 |
| Meeting Date | Bill Number or Topic |
| Appropriation Com. on HHS | |
| Committee | Amendment Barcode (if applicable) |

Name Katie Flury

Phone 407-768-9125

Address 6535 Nemours Pkwy
*Street*

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Orlando, FL 32827
*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 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 584 |
| INTRODUCER: | Education Postsecondary Committee and Senator Garcia |
| SUBJECT: | Young Adult Housing Support |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Palazesi | Bouck | HE | **Fav/CS** |
| 2. | Sneed | McKnight | AHS | **Favorable** |
| 3. | | | FP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 584 expands housing access and support services for students who are current or former foster youth or experiencing homelessness. The bill requires Florida College System (FCS) institutions and state universities, in coordination with the State Office on Homelessness within the Department of Children and Families (DCF), to develop plans prioritizing the placement of eligible students in campus housing. If an FCS institution or state university implements a housing or support assignment system, the institution must give first priority to homeless youth (as defined federally) for:

- Institution-operated housing.
- Year-round housing.
- Work-study opportunities.

The bill directs the DCF, community-based care lead agencies (CBCs), and municipal housing authorities to take actions necessary to implement the federal Foster Youth to Independence (FYI) housing initiative. This includes entering into a memorandum of understanding or a letter of intent, offering supportive services, and certifying child welfare history.

The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to study and report by December 1, 2026, barriers to housing for homeless and former foster youth and provide recommendations. The study must involve consultation with state agencies, housing authorities, and affected youth.

The bill will have an insignificant negative fiscal impact on state expenditures. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

### Homeless Youth and Children in Foster Care

Federal law provides a definition for the term "homeless children and youths," which means individuals who lack a fixed, regular, and adequate nighttime residence and includes children and youths who are:[1]

- Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason.
- Living in motels, hotels, trailer parks, or camping grounds due to the lack of adequate alternative accommodation.
- Living in emergency or transitional shelters or are abandoned in hospitals.
- Utilizing for a primary nighttime residence a place that is public or private, but not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
- Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.
- Migratory children living in circumstances described above.

The term "unaccompanied youth" includes a youth not in the physical custody of a parent or guardian.[2]

Florida law defines the term "children and youths who are experiencing homelessness" to have the same meaning as "homeless children and youths" under federal law.[3] A student in foster care refers to any child or youth who has been removed from their home and placed in the custody of the state due to abuse, neglect, or abandonment, and who is currently residing in a licensed foster home, group home, or other approved out-of-home placement under the oversight of the Department of Children and Families.[4]

In school year 2022-23, there were 94,889 students enrolled in Florida school districts that were identified as homeless[5] and there were 21,031 children (aged 0-17) in foster care.[6]

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[1] 42 U.S.C. s. 11434a(2).
[2] 42 U.S.C. s. 11434a(6).
[3] Section 1003.01(12), F.S.
[4] Section 39.001, F.S.
[55] Florida Department of Education, *2022-2023 Homeless Student Count, available at* https://www.fldoe.org/core/fileparse.php/20081/urlt/PERA-3356i-Homeless-and-Unaccom-Youth-2223-FS5-w-Charter-LEAs-DEH-Masked.pdf.
[6] Florida Department of Health, *FLHealthCharts,* https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?cid=8601&rdReport=NonVitalIndNoGrp.Dataviewer&utm_source=chatgpt.com, (last visited March 26, 2025).

**State Office on Homelessness**

The State Office on Homelessness was created within the DCF to provide interagency, council, and other related coordination on issues relating to homelessness[7] and is required to:[8]

- Coordinate among state, local, and private agencies and providers to produce a statewide consolidated inventory for the state's entire system of homeless programs which incorporates local continuum of care plans.
- Collect, maintain, and make available information concerning persons who are homeless, including summary demographic.
- Annually evaluate state and continuum of care system programs and develop a consolidated plan for addressing the needs of the homeless or those at risk for homelessness.
- Explore, compile, and disseminate information regarding public and private funding sources for state and local programs serving the homeless and provide technical assistance in applying for such funding.
- Monitor and provide recommendations for coordinating the activities and programs of continuums of care and promote the effectiveness of programs to prevent and end homelessness in the state.
- Provide technical assistance to facilitate efforts to support and strengthen continuums of care.
- Develop and assist in the coordination of policies and procedures relating to the discharge or transfer from the care or custody of state-supported or state-regulated entities persons who are homeless or at risk for homelessness.
- Spearhead outreach efforts for maximizing access by people who are homeless or at risk for homelessness to state and federal programs and resources.
- Promote a federal policy agenda that is responsive to the needs of those who are homeless or at risk of homelessness in this state.
- Review reports on continuum of care system performance measures and use such measures to evaluate program effectiveness and make recommendations for improving current practices to work toward ending homelessness in this state.
- Formulate policies and legislative proposals aimed at preventing and ending homelessness in this state and coordinate the implementation of state and federal legislative policies.
- Convene meetings and workshops of state and local agencies, continuums of care, and other stakeholders for the purpose of developing and reviewing policies, services, activities, coordination, and funding of efforts to end homelessness.
- With the input of the continuums of care, conduct or promote research on the effectiveness of current programs and propose pilot projects aimed at ending homelessness.
- Serve as an advocate for issues relating to homelessness.
- Investigate ways to improve access to participation in state funding and other programs for the prevention and reduction of homelessness to faith-based organizations and collaborate and coordinate with faith-based organizations.

[7] Section 420.622 (1), F.S.
[8] Section 420.622 (3)(a)-(o), F.S.

**Educational Support Structures for Children in the Foster Care System or who are Experiencing Homelessness**

The DCF is required to collaborate with the State University System, the Florida College System (FCS), and the Department of Education to address the need for a comprehensive support structure in the academic arena to assist children and young adults who have been or remain in the foster care system in making the transition from a structured care system into an independent living setting.[9]

Each school district program, FCS institution, or state university at which a student who is experiencing homelessness, and a current or former foster child or young adult is required to have, at a minimum, a knowledgeable, accessible, and responsive employee who acts as a liaison and provides assistance to those students who are exempt from the payment of tuition and fees to assist in resolving any problems related to such exemption.[10]

A school district program, FCS institution, or state university may also provide campus coaching services and other support to a student who is experiencing homelessness or current or former foster children and young adults to promote his or her successful completion of postsecondary education and transition to independent living.

***Postsecondary Education Services and Support (PESS) Program***

The Postsecondary Education Services and Support (PESS) Program is a program that provides monthly financial support for foster youth to secure housing, utilities, and assist with the daily cost of living while attending certain postsecondary educational institutions.[11]

A young adult is eligible for PESS if certain criteria are met, including:

- Specified criteria with respect to when the child was living in foster care;
- Earned a standard high school diploma;[12]
- Has been admitted for enrollment as a full-time[13] student or its equivalent in an eligible postsecondary institution as provided in s. 1009.533, F.S.;[14]
- Has reached 18 years of age, but is not yet 23 years old;
- Has applied for any other grants and scholarships for which he or she may qualify;
- Submitted a complete and error-free Free Application for Federal Student Aid; and

[9] Section 409.1452, F.S.
[10] Section 409.1452(1), F.S.
[11] Department of Children and Families, *Postsecondary Education Services and Support (PESS), available at* https://www.myflfamilies.com/services/child-family/independent-living/youth-young-adults/postsecondary-education-services-and (last visited March 27,2025).
[12] Pursuant to s. 1002.3105(5), F.S., s. 1003.4281, F.S., or s. 1003.4282, F.S., or its equivalent pursuant to s. 1003.435, F.S.
[13] Section 409.1451(2)(a)4., F.S., defines "full-time" as 9 credit hours or the vocational school equivalent.
[14] Section 1009.533, F.S., provides for eligible postsecondary education institutions, including: (1) a Florida public university, Florida College System institution, or career center; (2) An independent Florida college or university that is accredited by an accrediting association whose standards are comparable to the minimum standards required to operate an institution at that level in Florida and which has operated in the state for at least 3 years; (3) an independent Florida postsecondary education institution that is licensed by the Commission for Independent Education and meets other specified criteria; (4) a Florida independent postsecondary education institution that offers a nursing diploma approved by the Board of Nursing; and (5) A Florida independent postsecondary education institution that is licensed by the Commission for Independent Education.

- Signed an agreement to allow the DCF and the CBC to access his or her school records.[15]

***State University Systems Support***

Students who have experienced foster care or homelessness are exempt from the payment of tuition and fees, including lab fees, at a school district that provides workforce education programs, FCS institution, or state university.[16] In 2023-2024 there were 249 students who were in foster care and 432 students experiencing homelessness who received a fee exemption.[17] In addition to the fee exemption, several state universities offer comprehensive program designed specifically for students who have experienced foster care or homelessness.

Florida Atlantic University

Educate Tomorrow at Florida Atlantic University (FAU) is part of the First Year Experience at the university. The program provides students with wrap-around services from admission to graduation, with a goal of creating a strong foundation of support, academic coaching, career advising, and access to services on and off campus.[18]

Through collaboration with campus and community partners, the Educate Tomorrow at FAU Program offers the following services to students:[19]

- Referral to Academic Support Services
- AOK Scholars
- Opportunity to get involved in our sponsored student organization, Enlightening Generations (learn more)
- Referral to FREE campus tutoring
- Referral to campus engagement opportunities, such as First Gen
- Referral to campus resources such as Student Health Services, Counseling and Psychological Services, Financial Aid, and the Career Center
- Student advocacy and assistance throughout your time at FAU
- Independent living skills activities
- Opportunities to get involved on campus

Florida International University

Launched in 2014, Florida International University's (FIU) Fostering Panther Pride (FPP) program offers tailored academic and support services to former foster youth and students experiencing homelessness. The program's primary goal is to assist these students in their transition to FIU, their retention and graduation, and their pursuit of securing employment or graduate studies upon earning their bachelor's degree.[20]

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[15] Section 409.1451(2)(a), F.S.
[16] Section 1009.25, (1)(c), (e), F.S.
[17] Florida Board of Governors, *Fee Waiver Summary*, https://www.flbog.edu/resources/data-analytics/dashboards/fee-waiver-summary/, (last visited March 27, 2025).
[18] Florida Atlantic University, *Educate Tomorrow*, https://www.fau.edu/uas/educate-tomorrow/, (last visited March 27, 2025).
[19] *Id.*
[20] Florida International University, *Fostering Panther Pride*, https://sas.fiu.edu/fpp/, (last visited March 27, 2026).

FPP tailored support services and participation benefits include:[21]

- Processing DCF and homeless tuition exemption paperwork.
- Serve as liaisons between FPP students and FIU Housing & Residential Life to secure housing and promote a smooth transition into on-campus residence.
- Connecting students to community resources and partners (i.e.: Homeless Helpline, Educate Tomorrow, Voices for Children, HANDY, etc.).
- Access to the FPP Cupboard (food, toiletries, and other personal care items) and the university's Student Food Pantry.
- Dedicated Success Coaches provide students with a support system and help them navigate university processes pertaining to admissions, financial aid, registration, and housing. Staff also assist students with accessing institutional resources (i.e.: academic advising, tutoring, counseling services, career development services) for academic and professional development.
- Students are paired with FIU faculty, staff, and/or alumni mentors who serve as guides through their academic journey.
- Access to priority course registration.
- Laptop loaner program.
- Access to book stipends and housing scholarships.

University of Central Florida

The Knight Alliance Network (KAN) at the University of Central Florida (UCF) provides support services supporting the student success and well-being of youth who experience foster care, relative care, adopted, or homelessness. The KAN plays an essential role in the students' lives by focusing on the students' well-being and providing support services to encourage the completion of college. The KAN strategically partners with UCF campus and community partners, to promote the well-being of KAN students. The KAN offers the following services:[22]

- Pre-college enrollment support
- Transition support
- Goal setting
- Advocacy
- Assistance with waivers
- Assistance with navigating campus
- On-campus support services
- One on one counseling
- Coaching
- Resources
- Referrals
- Tuition Waiver Assistance
- Mentoring

[21] Florida International University, *Fostering Panther Pride*, https://sas.fiu.edu/fpp/, (last visited March 27, 2026).
[22] University of Central Florida, *Knight Alliance Network*, https://scs.sdes.ucf.edu/foster-youth-and-homeless-students/, (last visited March 27, 2025).

**Foster Youth to Independence Initiative**

The United States Department of Housing and Urban Development's (HUD) Foster Youth to Independence (FYI) Initiative is a federal program aimed at preventing homelessness among young adults who are aging out of foster care or have prior foster care experience. Introduced in 2019, the FYI initiative provides time-limited rental assistance through the Housing Choice Voucher Program, connecting young adults to supportive services from local community resources to help them develop essential life skills and achieve self-sufficiency.[23]

The FYI Initiative is designed for young adults who are transitioning out of foster care or have prior foster care experience and are homeless or at risk of experiencing homelessness. Young adults who are transitioning out of foster care or have prior foster care experience and are homeless or at risk of experiencing homelessness may receive housing assistance and supportive services for up to 36 months.

In Florida, local public housing authorities contract directly with HUD to offer housing vouchers like the FYI initiative. There are currently over 90 public housing agencies in Florida that participate in public housing assistance.[24]

**Office of Program Policy Analysis and Government Accountability**

The Office of Program Policy Analysis and Government Accountability (OPPAGA) is a research arm of the Florida Legislature. OPPAGA was created by the Legislature in 1994 to help improve the performance and accountability of state government. OPPAGA provides data, evaluative research, and objective analyses to assist legislative budget and policy deliberations. OPPAGA conducts research as directed by state law, the presiding officers, or the Joint Legislative Auditing Committee.[25]

## III. Effect of Proposed Changes:

**Comprehensive Academic Support Structure for Children in the Foster Care System**

The bill amends s. 409.1452, F.S., to require each Florida College System (FCS) institution and state university, in consultation with the State Office on Homelessness within the Department of Children and Families (DCF), to develop plans for prioritizing the placement of students who are or were formerly in foster care and those experiencing homelessness or at risk of experiencing homelessness. This includes, but is not limited to, students who qualify for a tuition and fee exemption based on meeting the federal definition of homeless children and youth, in residence halls and dormitory residences owned by the institution or university.

The bill provides that if an FCS institution or state university implements a priority system for assigning students to, or awarding any of the following, the institution or university must give

[23] U.S. Department of Housing and Urban Development, *FYI Brochure for Young Adults*, *available at* https://www.hud.gov/sites/default/files/PIH/documents/FosterYouthInitiativeBrochure-YoungAdult.pdf.
[24] U.S. Department of Housing and Urban Development, *Find Your Local Public Housing Agency (PHA), HA Contact Information by State: Florida*, https://www.hud.gov/program_offices/public_indian_housing/pha/contacts.
[25] Office of Program Policy and Government Accountability, *About Us*, https://oppaga.fl.gov/About (last visited Mar. 27, 2025).

first priority to students who qualify for a tuition and fee exemption based on meeting the federal definition of homeless children and youth:

- Institution-operated or university-operated housing.
- Year-round housing.
- Work-study opportunities.

The bill prohibits FCS institutions and state universities from requiring students to have a cosigner or guarantor to obtain housing if the student receives housing support through the Road to Independence Program or is in a continuing care program for young adults.

**Housing Support for Young Adults**

The bill creates s. 409.14525, F.S., to require the DCF, community-based care lead agencies, and housing authorities to take any action required by the United States Department of Housing and Urban Development to administer the federal Foster Youth to Independence (FYI) initiative. These actions may include DCF, the community-based care lead agencies, and their subcontractors doing any of the following:

- Entering into a memorandum of understanding or letter of intent with all housing authorities within their service areas.
- Providing or securing supportive services for participating youth for the duration of the FYI initiative voucher.
- Providing a written certification to the housing authority verifying the youth's child welfare history.

**The Office of Program Policy Analysis and Government Accountability Report**

The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct a study of the barriers that young adults who are homeless or were formerly in foster care face when trying to obtain housing. The study must include recommendations for overcoming those barriers. In conducting the study, OPPAGA is required to consult with the DCF, the Board of Governors of the State University System, the FCS, the Department of Commerce, public housing authorities, affected young adults, and other stakeholders.

The bill requires OPPAGA to report its findings by December 1, 2026, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The bill takes effect 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 bill is expected to have an insignificant negative fiscal impact on state expenditures. The Department of Children and Families and the Office of Program Policy Analysis and Government Accountability can absorb the requirements of the bill within existing resources.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 409.1452 of the Florida Statutes.

This bill creates section 409.14525 of the Florida Statutes.

This bill creates an undesignated section of Florida law.

## 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 Postsecondary on March 31, 2025:**
The committee substitute deleted provisions related to the assurances of payment for residential leases by the Department of Children and Families, community-based care agencies or subcontractors.

B. Amendments:

None.

**By** the Committee on Education Postsecondary; and Senator Garcia

589-03091-25 2025584c1

A bill to be entitled

An act relating to young adult housing support; amending s. 409.1452, F.S.; requiring each Florida College System institution and state university to develop plans for prioritizing the placement of certain students; requiring a Florida College System institution or state university to provide certain students with first priority for housing and work study opportunities in certain circumstances; prohibiting Florida College System institutions and state universities from requiring that certain students have a cosigner or guarantor; creating s. 409.14525, F.S.; requiring the Department of Children and Families, community-based care lead agencies, and housing authorities to take any action required by the United States Department of Housing and Urban Development to administer the federal Foster Youth to Independence initiative; requiring the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct a study of the barriers to housing faced by young adults who are homeless or were formerly in foster care; requiring OPPAGA to consult with certain entities in conducting the study; requiring OPPAGA to provide a report to the Governor and the Legislature by a certain date; providing an effective date.

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







589-03091-25 2025584c1

Section 1. Subsections (4), (5), and (6) are added to section 409.1452, Florida Statutes, to read:

409.1452 Collaboration with State University System, Florida College System, and Department of Education to assist children and young adults who have been or are in foster care or are experiencing homelessness; documentation regarding eligibility for tuition and fee exemptions; housing assistance.—The department shall collaborate with the State University System, the Florida College System, and the Department of Education to address the need for a comprehensive support structure in the academic arena to assist children and young adults who have been or remain in the foster care system in making the transition from a structured care system into an independent living setting.

(4) Each Florida College System institution and state university shall, in consultation with the State Office on Homelessness within the Department of Children and Families, develop plans for prioritizing the placement of students who are or were formerly in foster care and those experiencing homelessness or at risk of experiencing homelessness, including, but not limited to, students eligible for the tuition and fee exemption under s. 1009.25(1)(e), in residence halls and dormitory residences owned by the institution or university.

(5) If a Florida College System institution or state university implements a priority system for the assignment of students to or the award of any of the following, the institution or university must provide students eligible for the tuition and fee exemption under s. 1009.25(1)(e) with first priority:

(a) Institution-operated or university-operated housing.

(b) Year-round housing.

(c) Work study opportunities.

(6) Florida College System institutions and state universities may not require students to have a cosigner or guarantor to obtain housing if the student receives housing support under s. 409.1451(2) or (3) or is in care under s. 39.6251.

Section 2. Section 409.14525, Florida Statutes, is created to read:

409.14525 Housing support for young adults; federal housing vouchers.—The department, community-based care lead agencies, and housing authorities created under s. 421.04 shall take any action required by the United States Department of Housing and Urban Development to administer the federal Foster Youth to Independence (FYI) initiative, which may include the department, the community-based care lead agencies, and their subcontractors doing any of the following:

(1) Entering into a memorandum of understanding or a letter of intent with all of the housing authorities within their service areas.

(2) Providing or securing supportive services for participating youth for the duration of the FYI initiative voucher.

(3) Providing a written certification to the housing authority verifying the youth's child welfare history.

(4) Identifying youth eligible for an FYI initiative voucher within the community-based care lead agency's caseload and communicating their eligibility to the youth.





Section 3. (1) The Office of Program Policy Analysis and Government Accountability (OPPAGA) shall conduct a study of the barriers that young adults who are homeless or were formerly in foster care face when trying to obtain housing. The study must include recommendations for overcoming those barriers.

(2) In conducting the study, OPPAGA shall consult with the Department of Children and Families, the Board of Governors of the State University System, the Florida College System, the Department of Commerce, public housing authorities, affected young adults, and other stakeholders.

(3) OPPAGA must issue its findings by December 1, 2026, in a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 4. This act shall take effect July 1, 2025.

The Florida Senate

# Committee Agenda Request

**To:** Senator Jay Trumbull, Chair
Appropriations Committee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** March 31, 2025

---

I respectfully request that **Senate Bill #584**, relating to Young Adult Housing Support, be placed on the:

☐ Committee agenda at your earliest possible convenience.

☒ Next committee agenda.

Senator Ileana Garcia
Florida Senate, District 36

File signed original with committee office

S-020 (03/2004)

The Florida Senate

# APPEARANCE RECORD

Deliver both copies of this form to
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April 10, 2025
Meeting Date

Health & Human Services Appropriations
Committee

SB 584
Bill Number or Topic

Amendment Barcode (if applicable)

Name Noah Corcoran

Phone (352) 422-8266

Address 112 E. Jefferson St.
*Street*

Email noah@corcoranpartners.com

Tallahassee FL 32301
*City* *State* *Zip*

Reset Form

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 Youth Shine

☐ 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

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4-10-2025
Meeting Date

HHS Appropriations
Committee

SB 584
Bill Number or Topic

Amendment Barcode (if applicable)

Name Austin Lawson

Phone 352-634-9427

Address 333 Camino Gardens Blvd, Suite 202
Street

Email Austin@floridyouthshine.org

Boca Raton FL 33432
City State Zip

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

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S-001 (08/10/2021)

The Florida Senate

# APPEARANCE RECORD

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| 4/10/2025 | SB 584 |
|---|---|
| Meeting Date | Bill Number or Topic |
| Appropriations Committee on Health and Human Services | |
| Committee | Amendment Barcode (if applicable) |

Name Qua'viona Peeples

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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:

*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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | SB 788 |
| INTRODUCER: | Senators Truenow and Gaetz |
| SUBJECT: | Veterans' Nursing Homes |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Proctor | Proctor | MS | **Favorable** |
| 2. | Howard | McKnight | AHS | **Favorable** |
| 3. | | | FP | |

## I. Summary:


SB 788 provides a licensed skilled nursing facility on the campus of a retirement community qualified for nonprofit status under section 501(c)(3) of the Internal Revenue Code which provides housing for only veterans, their spouses, and surviving spouses, may request to create or modify the designation of specific beds exclusively for veterans and their spouses if specific criteria are met.

The bill authorizes the director of the Florida Department of Veterans' Affairs (FDVA) to approve requests to create or modify the designation of specific beds exclusively for veterans and their spouses under certain criteria.

The bill provides an exemption from the requirement to obtain a Certificate of Need (CON) from the Agency for Health Care Administration for:

- State veterans' nursing homes operated by or on behalf of the FDVA that are constructed with state or federal funds and where the federal government pays a per diem rate not to exceed one-half of the cost of the veterans' care.
- The consolidation or combination of licensed nursing homes or the transfer of beds between licensed nursing homes that are for the sole use of veterans, their spouses, or surviving spouses, by nursing homes with any shared controlled interest and if the site of the relocation is not more than 100 miles from the original location.

The FDVA may adopt rules to administer the provisions of the bill regarding the approval of veteran- and spouse designated nursing home beds.

The bill has no fiscal impact on state revenues or expenditures. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

### Florida Department of Veterans' Affairs

The Florida Department of Veterans' Affairs (FDVA) is a constitutionally chartered[1] department that was created to provide assistance to all former, present, and future members of the Armed Forces of the United States and their spouses and dependents in preparing claims for and securing compensation, hospitalization, career training, and other benefits or privileges to which they are, or may become entitled to under federal or state law or regulation by reason of their service.[2] The FDVA operates a network of nine state veterans' homes and provides statewide outreach to connect veterans with services, benefits, and support.[3] The FDVA offers benefits and services in the fields of health care, mental health and substance abuse, claims support, education, employment, housing, burial benefits, and legal assistance.[4] There are about 1.4 million veterans living in Florida, making the state's veteran population the third largest nationally.[5]

#### *Veterans Nursing Homes*

The FDVA provides care for veterans in both domiciliary homes and nursing facilities.[6] Both veterans of wartime and peacetime service are eligible for admission.[7] Veterans are admitted to both types of facilities based on a priority ranking.[8] To be considered for admission to a veterans' home in Florida, a veteran must have been discharged from the military with either an honorable or an upgrade to an honorable discharge.[9]

Each veterans' nursing home is overseen by an administrator who is selected by the executive director (director) of the FDVA.[10]

To be eligible for admission, a veteran must:
- Be in need of nursing care.
- Be a resident of the state at the time of application for admission to the home.
- Not owe money to the FDVA for services rendered during any previous stay at an FDVA facility.

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[1] FLA. CONST. art. IV, s. 11.
[2] Section 292.05(1), F.S.
[3] Fla. Dep't of Veterans' Affairs, *Executive Director's Message*, *available at* https://www.floridavets.org/leadership/ (last visited Mar. 20, 2025).
[4] Fla. Dep't of Veterans' Affairs, *Benefits & Services*, *available at* https://www.floridavets.org/benefits-services/ (last visited Mar. 20, 2025).
[5] Fla. Dep't of Veterans' Affairs, *Our Veterans*, *available at* https://floridavets.org/our-veterans/ (last visited Mar. 20, 2025).
[6] Chapter 296, F.S.
[7] Sections 296.08 and 296.36, F.S. "Wartime service" is defined as service in any of the following campaigns or expeditions: Spanish-American War (1898-1902); Mexican Border Period (1916-1917); World War I (1917-1918, with qualifying extensions until 1921); World War II (1941-1946); Korean War (1950-1955); Vietnam War, (1961-1975); Persian Gulf War (1990-1992); Operation Enduring Freedom (2001-date prescribed by presidential proclamation or by law); Operation Iraqi Freedom (2003-date prescribed by presidential proclamation or by law). Peacetime service is defined as any Army, Navy, Marines, Coast Guard, Air Force, or Space Force service not in any of the campaigns or expeditions. Section 1.01(14), F.S.
[8] Sections 296.08 and 296.36, F.S.
[9] Sections 296.02(9) and 1.01(14), F.S.
[10] Section 296.34, F.S.

- Have applied for all financial assistance reasonably available through governmental sources.
- Have been approved as eligible for care and treatment by the United States Department of Veterans Affairs (VA).[11]

Eligible veterans are given priority for admission to a home in the following order, veterans who:
- Are residents of the state.
- Have a service-connected disability as determined by the VA, or who were discharged or released from service for a disability incurred or aggravated in the line of duty and the disability is the condition for the nursing home need.
- Have a non-service-connected disability and are unable to defray the cost of nursing home care.[12]

A spouse or surviving spouse of an eligible veteran is also eligible for admission at the bottom of the priority list.[13] The director of the FDVA may waive the residency requirement for an otherwise qualified veteran if the veteran is a disaster evacuee of a state under a declared state of emergency.[14]

The FDVA currently operates eight skilled nursing facilities throughout the state. The nursing homes are located in Daytona Beach, Orlando, Land O'Lakes, Pembroke Pines, Panama City, Port Charlotte, Port St. Lucie, and St. Augustine, Florida.[15]

***Cost and Funding of Resident Care***

A resident of a state veterans' home must contribute to the cost of his or her care if the resident receives a pension, compensation, gratuity from the federal government, or income from any other source of more than $100 per month for domiciliary homes and $160 per month for nursing homes.[16]

In addition to the resident's portion of payment, the VA provides a reimbursement care subsidy to domiciliary homes and nursing homes based on a per diem rate.[17] The current VA per diem for domiciliary homes is $59.69 a day.[18] The current VA per diem for basic care in a nursing home is set at $138.29 a day,[19] while per diem for disabled veterans who are determined to be at least 70 percent disabled varies by location in the state from $504.03 a day in Daytona to $551.04 a

[11] Section 296.36(1), F.S.
[12] Section 296.36(3), F.S.
[13] *Id*.
[14] Section 296.36, F.S.
[15] Fla. Dep't of Veterans' Affairs, *State Veterans' Homes*, *available at* https://floridavets.org/locations/state-veterans-nursing-homes/ (last visited Mar. 20, 2025).
[16] Sections 296.10 and 296.37, F.S. This contribution for care may be 100 percent of the cost if an otherwise eligible veteran is able to fund his or her own support.
[17] 38 C.F.R. s. 51.390 and 38 C.F.R. s. 51.210.
[18] U.S. Dep't of Veterans Affairs, Geriatric and Extended Care, State Home Per Diem Program, *State Home Per Diem Basic Rates for FYs 2000-2024, available at* https://www.va.gov/geriatrics/pages/State_Veterans_Home_Program_per_diem.asp (last visited Mar. 20, 2025).
[19] *Id*.

day in Pembroke Pines.[20] To qualify for reimbursement, federal law requires at least 75 percent of the population of the facility to be veterans.[21] This threshold drops to 50 percent if the facility was constructed or renovated solely by the state.[22]

Federal law authorizes a state veterans' home to house non-veteran residents who are spouses of veterans or parents whose children died while in military service.[23] These residents may be required to pay for the full cost of their care since the VA does not provide a reimbursement care subsidy to domiciliary homes and nursing homes for these individuals.

***VA Community Nursing Home (CNH) Program***

Federal law authorizes the VA to contract with community nursing homes to provide care for eligible veterans.[24] Separate guidelines are outlined giving authority for the VA to place eligible veterans in non-VA facilities when necessary[25] and the requirements for State Veterans' Homes,[26] which are separate from the CNH Program but often related in the types of care that is offered.

For all types of VA skilled nursing home care, veterans must be eligible (and enrolled) in the VA health care benefit system, also called the standard medical benefits package, via the Veterans Health Administration and meet the following eligibility requirements:

- Must not have been dishonorably discharged.
- Must have served on active duty in the military, air, or naval service.
- Must have served 24-months continuously or the full active duty period in which one was called if enlisted after September 7, 1980, or became active duty after October 16, 1981. This minimum active duty criteria is not applicable for veterans who actively served before September 7, 1980, or were discharged due to a disability that resulted from, or was worsened, by active duty, or had an early-out or hardship discharge.
- National Guard or Reserves members (current and former) must have served on active duty per a federal order and served the entire period as ordered. Active duty status for training only does not count. [27]

CNHs must provide 24-hour skilled nursing care (such as wound care or help with IV medication), occupational and physical therapy, and access to social work services. Additionally, some CNHs provide short term rehab services, hospice and palliative care for the end of life, and specialized care for dementia. [28]

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[20] Email from Jeff Obos, Public Information Administrator, Fla. Dep't of Veterans' Affairs, to Roy Clark, Director of Cabinet and Legislative Affairs, Fla. Dep't of Veterans' Affairs (Mar. 21, 2025) (on file with the Senate Committee on Military and Veterans Affairs, Space, and Domestic Security).
[21] 38 C.F.R. s. 51.210(d).
[22] *Id*.
[23] *Id*.
[24] 38 U.S.C. s. 1720.
[25] 38 C.F.R. s. 17.51.
[26] 38 C.F.R. s. 51.20. *See also* 38 C.F.R. s 51.30.
[27] American Council on Aging, Veterans Nursing Homes: Community Living Centers, *Community Nursing Homes & State Veterans Homes, available at* https://www.medicaidplanningassistance.org/veterans-nursing-homes/ (last visited Mar. 20, 2025).
[28] U.S. Dep't of Veterans Affairs, *Community Nursing Home, available at* https://www.va.gov/GERIATRICS/docs/Community_Nursing_Home.pdf (last visited Mar. 20, 2025).

## Certificate of Need

A Certificate of Need (CON) is a written statement issued by the Agency for Health Care Administration (AHCA) evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or hospice.[29]

### *Certificate of Need Program*

Florida's CON program has existed since July 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act of 1974 (Act), which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.[30] Each state was required to have a CON program in compliance with the Act as a condition for obtaining federal funds for health programs. The Act was repealed in 1986, but Florida retained its CON program.

The CON program is a regulatory process that requires certain health care providers to obtain state approval before offering certain new or expanded services. The CON program currently regulates hospices, freestanding inpatient hospice facilities, skilled nursing facilities and intermediate care facilities for the developmentally disabled. It does not regulate outpatient services, home health services, purchases of major medical equipment, assisted living facilities, and hospitals.[31]

The Florida CON program has three levels of review: full, expedited, and exempt.[32] Expedited review is primarily targeted towards nursing home projects.

### *Determination of Need, Application, and Review Process*

Most projects are reviewed on a competitive batching cycle review basis. At least 30 days prior to the application deadline for a batch cycle, an applicant must file a letter of intent with the AHCA.[33] A letter of intent is not required for projects that will be given a non-competitive, expedited review.[34] A letter of intent must describe the proposal, specify the number of beds sought, and identify the services to be provided and the location of the project.[35]

Within 60 days after receipt of the completed applications for that batch, the AHCA must issue a State Agency Action Report and Notice of Intent to Award a CON for a project in its entirety, to award a CON for identifiable portions of a project, or to deny a CON for a project.[36] The AHCA must then publish the decision, within 14 days, in the Florida Administrative Weekly.[37] If no

[29] Section 408.032(3), F.S.
[30] Pub. Law No. 93-641, 42 U.S.C. s. 300k et seq.
[31] Fla. Agency for Health Care Administration, *Certificate of Need (CON) Program Overview*, available at https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/certificate-of-need-con-program-overview (last visited March 20, 2025).
[32] Section 408.036, F.S.
[33] Section 408.039(2)(a), F.S
[34] Fla. Agency for Health Care Administration, *supra* note 31.
[35] Section 408.039(2)(c), F.S
[36] Section 408.039(4)(b), F.S.
[37] Section 408.039(4)(c), F.S.

administrative hearing is requested within 21 days of the publication, the State Agency Action Report and the Notice of Intent to Award the CON become a final order of the AHCA.[38]

***Projects Subject to Expedited CON Review***

Certain projects are eligible for expedited CON review. Applicants for expedited review are not subject to the application deadlines associated with full comparative review and may submit an application at any time. Projects subject to an expedited review include:

- Transfer of a CON.
- Replacement of a nursing home, if the proposed project site is within a 30-mile radius of the replaced nursing home. If the proposed project site is outside the subdistrict where the replaced nursing home is located, the prior 6-month occupancy rate for licensed community nursing homes in the proposed subdistrict must be at least 85 percent in accordance with the agency's most recently published inventory.
- Replacement of a nursing home within the same district, if the proposed project site is outside a 30-mile radius of the replaced nursing home but within the same subdistrict or a geographically contiguous subdistrict. If the proposed project site is in the geographically contiguous subdistrict, the prior 6-month occupancy rate for licensed community nursing homes for that subdistrict must be at least 85 percent in accordance with the agency's most recently published inventory.
- Relocation of a portion of a nursing home's licensed beds to another facility or to establish a new facility within the same district or within a geographically contiguous district, if the relocation is within a 30-mile radius of the existing facility and the total number of nursing home beds in the state does not increase.
- Construction of a new community nursing home in a retirement community under certain conditions.[39]

***Exemptions on CON Review***

Upon request, certain projects may be provided with an exemption to a CON review, many involving hospitals, including:

- Converting licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, so long as the conversion of the beds does not involve the construction of new facilities.
- Adding nursing home beds at a skilled nursing facility that is part of a retirement community offering a variety of residential settings and services.[40]
- Building an inmate health care facility by or for the exclusive use of the Department of Corrections.
- Adding nursing home beds in a number not exceeding 30 total beds or 25 percent of the number of beds licensed in the facility being replaced in certain circumstances.
- State veterans' nursing homes operated by or on behalf of the FDVA.
- Combining within one nursing home facility of the beds or services authorized by two or more CON issued in the same planning subdistrict.

[38] Section 408.039(4)(d), F.S

[39] Section 408.036(2), F.S.

[40] Section 408.036(3)(c). F.S. This exemption is limited to a retirement community that had been incorporated in Florida and operating for at least 65 years as of July 1, 1994.

- Dividing into two or more nursing home facilities of beds or services authorized by one CON issued in the same planning subdistrict.
- Adding nursing home beds licensed in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater; or, for adding nursing home beds licensed at a facility that has been designated as a Gold Seal nursing home in a number not exceeding 20 total beds or 10 percent of the number of licensed beds in the facility being expanded, whichever is greater.
- Replacing a licensed nursing home on the same site, or within five miles of the same site if within the same subdistrict, if the number of licensed beds does not increase, except in certain circumstances.
- Consolidating or combining of licensed nursing homes or transfer of beds between licensed nursing homes within the same planning district, by nursing homes with any shared controlled interest within that planning district, if there is no increase in the planning district total number of nursing home beds and the site of the relocation is not more than 30 miles from the original location.
- For beds in state mental health treatment facilities, state mental health forensic facilities and state developmental disabilities centers.
- Establishing a health care facility or project that meets all the following criteria:
  - The applicant was previously licensed within the past 21 days as a health care facility or provider that is subject to CON.
  - The applicant failed to submit a renewal application and the license expired on or after January 1, 2015.
  - The applicant does not have a license denial or revocation action pending with the agency at the time of the request.
  - The applicant's request is for the same service type, district, service area, and site for which the applicant was previously licensed.
  - The applicant's request, if applicable, includes the same number and type of beds as were previously licensed.
  - The applicant agrees to the same conditions that were previously imposed on the CON or on an exemption related to the applicant's previously licensed health care facility or project.
  - The applicant applies for initial licensure as required under s. 408.806, F.S., within 21 days after the agency approves the exemption request. If the applicant fails to apply in a timely manner, the exemption expires on the 22nd day following the agency's approval of the exemption.[41]

***CON Fees***

An applicant for CON review must pay a fee to the AHCA when the application is submitted. The minimum CON application filing fee is $10,000.[42] In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however, the total fee may not exceed $50,000.[43]

[41] Section 408.036(3), F.S.
[42] Section 408.038(1), F.S.
[43] Section 408.038(2), F.S.

A request for a CON exemption must be accompanied by a $250 fee payable to the AHCA.[44]

## III. Effect of Proposed Changes:

The bill amends s. 296.33, F.S., to define "veteran- and spouse-designated nursing home beds" to mean beds that are designated only for residents admitted in accordance with s. 296.36, F.S., to a licensed skilled nursing facility on the campus of a retirement community qualified for nonprofit status under s. 501(c)(3) of the Internal Revenue Code which provides housing for only veterans, their spouses, and surviving spouses.

The bill creates s. 296.411, F.S., to provide that the director of the Florida Department of Veterans Affairs (FDVA) may approve requests to create or modify veteran- and spouse-designated nursing home beds at a facility so long as any such beds operate in the VA Community Nursing Home Program and are in accordance with the requirements of ss. 296.35, 296.36, 296.37, and 296.41, F.S. The bill authorizes the FDVA to adopt rules to administer this process.

The bill amends s. 408.036(3), F.S., to revise exemptions to the Certificate of Need (CON) process for veterans nursing homes by providing that a CON is not required for:

- State veterans' nursing homes operated by or on behalf of the FDVA that are constructed with state or federal funds and for which the federal government pays a per diem rate not to exceed one-half of the cost of the veterans' care.
- The consolidation or combination of licensed nursing homes or the transfer of beds between licensed nursing homes that are for the sole use of veterans, their spouses, or surviving spouses, by nursing homes with any shared controlled interest and if the site of the relocation is not more than 100 miles from the original location.

The bill takes effect July 1, 2025.

## IV. Constitutional Issues:

### A. Municipality/County Mandates Restrictions:

Not applicable. The mandate restrictions do not apply because the bill does not require counties and municipalities to spend funds, reduce counties or municipalities' ability to raise revenue, or reduce the percentage of state tax shared with counties and municipalities.

### B. Public Records/Open Meetings Issues:

None identified.

### C. Trust Funds Restrictions:

None identified.

[44] Section 408.036(4), F.S., and Rule 59C-1.005(2)(g), F.A.C.

D. State Tax or Fee Increases:

None identified.

E. Other Constitutional Issues:

None identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None identified.

B. Private Sector Impact:

The bill may have an indeterminant positive fiscal impact on a licensed skilled nursing facility on the campus of a retirement community qualified for nonprofit status under s. 501(c)(3) of the Internal Revenue Code which provides housing for only veterans, their spouses, and surviving spouses, who requests to create or modify the designation of specific beds exclusively for veterans and their spouses under the provisions of the bill, and whose request is approved by the director of the Florida Department of Veterans Affairs.

C. Government Sector Impact:

None identified.

## VI. Technical Deficiencies:

None identified.

## VII. Related Issues:

None identified.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 296.33 and 408.036.

This bill additionally creates section 296.411 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.

**By** Senator Truenow

13-01578-25 2025788__

A bill to be entitled

An act relating to veterans' nursing homes; amending s. 296.33, F.S.; defining the term "veteran- and spouse-designated nursing home beds"; creating s. 296.411, F.S.; authorizing the executive director of the Department of Veterans' Affairs to approve requests to create or modify veteran- and spouse-designated nursing home beds if certain conditions are met; authorizing the department to adopt rules; amending s. 408.036, F.S.; revising exemptions from certificate of need requirements for certain projects relating to veterans' nursing homes; providing an effective date.

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

Section 1. Subsection (7) is added to section 296.33, Florida Statutes, to read:

296.33 Definitions.—As used in this part, the term:

(7) "Veteran- and spouse-designated nursing home beds" means beds that are designated only for residents admitted in accordance with s. 296.36 to a licensed skilled nursing facility on the campus of a retirement community qualified for nonprofit status under s. 501(c)(3) of the Internal Revenue Code which provides housing for only veterans, their spouses, and surviving spouses.

Section 2. Section 296.411, Florida Statutes, is created to read:

296.411 Approval; veteran- and spouse-designated nursing







13-01578-25 2025788__

home beds.—The director may approve requests to create or modify veteran- and spouse-designated nursing home beds at a facility so long as any such beds operate in the United States Department of Veterans Affairs Community Nursing Home Program and are in accordance with the requirements of ss. 296.35, 296.36, 296.37, and 296.41. The department may adopt rules to administer this section.

Section 3. Paragraph (f) of subsection (3) of section 408.036, Florida Statutes, is amended, and paragraph (n) is added to that subsection, to read:

408.036 Projects subject to review; exemptions.—

(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from subsection (1):

(f) For state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs in accordance with part II of chapter 296 for which ~~at least 50 percent of~~ the construction cost is ~~federally~~ funded by the state or the Federal Government and for which the Federal Government pays a per diem rate not to exceed one-half of the cost of the veterans' care in such state nursing homes. These beds may ~~shall~~ not be included in the nursing home bed inventory.

(n) For the consolidation or combination of licensed nursing homes or the transfer of beds between licensed nursing homes that are for the sole use of veterans, their spouses, or surviving spouses in accordance with part II of chapter 296, by nursing homes with any shared controlled interest and if the site of the relocation is not more than 100 miles from the original location.

Section 4. This act shall take effect July 1, 2025.

The Florida Senate

# APPEARANCE RECORD

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

4/10/25
Meeting Date

788
Bill Number or Topic

Approps committee HHS
Committee

Amendment Barcode (if applicable)

Name Tom Parker

Phone 850 224 3907

Address 307 W Park Ave
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Email TParker@FHCA.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 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)*

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

4/10/25
Meeting Date

HHS Approps
Committee

788
Bill Number or Topic

Amendment Barcode (if applicable)

Name Bob Asztalos

Phone 850-284-1166

Address 2601 Blair Stone Rd
Street

Email bob.Asztalos@fdva.fl.gov

Tallahassee FL 32399
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:
FDVA

☐ 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**

# 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 976 |
| INTRODUCER: | Children, Families, and Elder Affairs Committee and Senator Bernard |
| SUBJECT: | Court-appointed Psychologists |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Tuszynski | Tuszynski | CF | **Fav/CS** |
| 2. | Sneed | McKnight | AHS | **Favorable** |
| 3. | | | FP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 976 clarifies the process which a parent seeking to disqualify a court-appointed psychologist must follow, and also clarifies that moving to disqualify the psychologist is not a condition precedent to filing a supplemental legal action against the psychologist. Additionally, the bill clarifies that a two-way attorney fee shifting provision applies in any supplemental legal actions against the psychologist in his or her capacity as a court appointee, and does not apply to the underlying legal action.

The bill also requires the parent first move to disqualify the psychologist and appoint a different, alternative psychologist before a parent can file an administrative complaint against a court-appointed psychologist.

The bill will likely have an insignificant negative fiscal impact on state expenditures and revenues. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

### Family Law

In Florida, the general reference to "family law" matters include many different types of cases. Family law courts have jurisdiction over cases involving:

- Dissolution of marriage.
- Annulment.
- Child support.
- Paternity.
- Adoption.
- Name changes.
- Civil domestic violence, repeat violence, dating violence, stalking, and sexual violence injunctions.
- Juvenile dependency.
- Modifications and enforcements of orders, and more.[1]

### *Best Interests of the Child Standard*

Throughout all family law proceedings involving a minor child, the primary focus of the court is on the best interest of the minor child. Thus, when determining any issue involving child custody, the judge must first assess how his or her order would impact the child. Florida law provides a non-exhaustive list of 20 factors that a court must consider to determine the best interests of a minor child.[2] The factors affecting the welfare and interests of the child and the circumstances of the family, include, but are not limited to the:

- Demonstrated capacity and disposition of each parent to facilitate and encourage a continuing parent-child relationship, honor the timesharing schedule, and accommodate necessary changes.
- Anticipated division of parental responsibilities after the litigation, including the extent to which parental responsibilities will be delegated to third parties.
- Demonstrated capacity and disposition of each parent to determine, consider, and act upon the needs of the child.
- Length of time the child has lived in a stable environment and the desirability of maintaining continuity.
- Geographic viability of the parenting plan, with special attention paid to the needs of school-age children and the amount of time to be spent traveling to effectuate the parenting plan.
- Mental health, physical health, and moral fitness of the parents.
- Home, school, and community record of the child.
- Reasonable preference of the child.[3]
- Demonstrated knowledge, capacity, and disposition of each parent to be informed of the circumstances of the minor child, including the child's friends, teachers, and daily activities.

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[1] Florida Office of the State Courts Administrator, *Family Court in Florida*, available at: https://www.flcourts.gov/Resources-Services/Office-of-Family-Courts/Family-Court-in-Florida (last visited March 26, 2025).
[2] Section 61.13(3), F.S.
[3] Section 61.13(3), F.S.

- Demonstrated capacity and disposition of each parent to:
  - Provide a consistent routine; and
  - Communicate with and keep the other parent informed of issues and activities regarding the minor child, and the willingness of each parent to adopt a unified front on all major issues when dealing with the child.
- Evidence of domestic violence, sexual violence, child abuse, child abandonment, or child neglect, or evidence that a parent has or has had a reasonable cause to believe that he or she or his or her minor child or children are in imminent danger of becoming victims of an act of domestic violence.
- Evidence that either parent has ever knowingly provided false information about to the court regarding any prior or pending action regarding domestic violence, sexual violence, child abuse, child abandonment, or child neglect.
- Particular parenting tasks customarily performed by each parent, including the extent to which parenting responsibilities were undertaken by third parties.
- Demonstrated capacity and disposition of each parent to participate and be involved in the child's school and extracurricular activities.
- Demonstrated capacity and disposition of each parent to maintain an environment for the child which is free from substance abuse.
- Capacity and disposition of each parent to protect the child from the ongoing litigation regarding child custody.
- Developmental stages and needs of the child and the demonstrated capacity and disposition of each parent to meet the child's developmental needs.
- Any other factor that is relevant to the determination of a specific parenting plan, including the time-sharing schedule.

***Parental Responsibility***

Florida courts have consistently ruled that a parent's desire and right to the companionship, care, custody, and management of his or her children is an important interest that warrants deference and, absent a powerful countervailing interest, protection. Further, a parent has general responsibilities owed to his or her children, including supervision, health and safety, education, care, and protection. In Florida, parenting is broken down into two distinct components: parental responsibility (decision-making) and timesharing (physical visitation with the child based on a parenting plan). Although the right to integrity of the family is among one of the most fundamental rights, when parents divorce or separate, the parents' rights are subject to the overriding concern for the ultimate welfare or best interests of their children.

In family law matters, the commonly referred to idea of "custody" is broken down into parental responsibility and timesharing. Parental responsibility refers to the legal duty and right of a parent to care for, protect, and raise his or her child, including making important decisions regarding the child's upbringing and welfare such as religion, medical decisions, and education issues. Timesharing refers to the actual schedule each parent spends with the child according to a timesharing schedule detailed in a parenting plan.

Under Florida law, a court generally orders parental responsibility of a minor child to be shared by both parents.[4] However, a court may deviate from shared parental responsibility if it finds that shared parental responsibility would be detrimental to the minor child.[5] In determining whether there would be a detriment to the child, the court shall consider:

- Evidence of domestic violence;[6]
- Whether either parent has or has had a reasonable cause to believe that he or she or his or her minor child or children are or have been in imminent danger of becoming victims of domestic violence or sexual violence by the other parent against the parent or against the child or children whom the parents share in common, regardless of whether a cause of action has been brought or is pending on the issue;
- Whether either parent has or has had reasonable cause to believe that his or her minor child or children are or have been in imminent danger of becoming victims of an act of abuse, abandonment, or neglect by the other parent; and
- Any other relevant factors.[7]

Current law provides factors that create a rebuttable presumption that shared parental responsibility is detrimental to the child, as follows:

- A parent has been convicted of a first-degree misdemeanor or higher level of crime involving domestic violence as defined in s. 741.28, F.S., and ch. 775, F.S.;
- A parent meets the criteria for the termination of his or her parental rights under s. 39.806(1)(d), F.S. relating to a parent who is incarcerated; or
- A parent has been convicted of or had adjudication withheld as a sexual offender for an offense enumerated in s. 943.0435(1)(h)1.a., F.S., and at the time of the offense the parent was 18 years old or older and the victim was under 18 years old or the parent believed the victim to be under 18.[8]

***Parenting Plan***

A court may prescribe a "parenting plan"[9] by which the parents are ordered to share decision-making and physical custody of the minor child. The parenting plan may order parents to exercise shared parental responsibility, it may delegate decision-making authority over specific matters to one parent, or it may grant a parent sole parental responsibility over the minor child. Common issues concerning a minor child may include education, healthcare, and social or emotional wellbeing.

A parenting plan is a document created to govern the relationship between parents relating to decisions that must be made regarding the minor child at issue.[10] A parenting plan must contain a timesharing schedule for the parents and the child.[11] The parenting plan should attempt to

[4] Section 61.13(2)(c)(2), F.S.
[5] *Id*.
[6] Section 741.28, F.S.
[7] Section 61.13(2)(c)(2), F.S.
[8] Section 61.13(2)(c)(3), F.S.
[9] A "parenting plan" is a document created to govern the relationship between the parents relating to decisions which must be made regarding the child and must contain a timesharing schedule for the parents and child. S. 61.046(14), F.S. If a parenting plan is agreed to by the parties, it must be approved by the court.
[10] Section 61.046(14), F.S.
[11] *Id*.

address all issues concerning the minor child, including, but not limited to, the child's education, health care, and physical, social, and emotional well-being.[12] In creating the parenting plan, the court must consider all circumstances between the parents, including their historic relationship, domestic violence, and other factors.[13] A parenting plan is either created and agreed to by both parents and approved by the court, or is established by the court if the parents cannot agree to a plan or the parents agree to a plan that is not approved by the court.[14] A parenting plan may be utilized in cases involving minor children unrelated to a dissolution of marriage or in connection to a dissolution of marriage.

A parenting plan approved by the court must, at a minimum:

- Describe in adequate detail how the parents will share and be responsible for the daily tasks associated with raising the minor child;
- Include the timesharing schedule arrangements that specify the time that the minor child will spend with each parent;
- Designate which parent will be responsible for healthcare, school-related matters, and other activities; and
- Describe in adequate detail the methods and technologies the parents will use to communicate with the child.[15]

Given the potential for heated disputes in matters involving a minor child, it is imperative that the parenting plan be as detailed as possible to eliminate ambiguity surrounding each parent's responsibilities and specific timesharing with the minor child. This generally includes a detailed description of the various holidays and with which parent the child will spend each holiday,[16] the location of the exchange from one parent's timesharing to the other parent's timesharing, who is responsible for the child's travel expenses, the times during which one parent will ensure the minor child is available to communicate with the other parent, the delegation of specific decision-making topics, and more.[17]

To assist parties with creating a parenting plan that meets the requirements under s. 61.13, F.S., the Florida Supreme Court has published a standardized parenting plan form, Form 12.995(a).[18] The form attempts to cover all possible aspects of an acceptable parenting plan including which parent can enroll the child in extra-curricular activities, the specific meaning of academic breaks and holidays, the process by which a parent should request a temporary schedule change, the specific days the child should be with each parent, and the specific time the exchange should occur.

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[12] Section 61.046(14), F.S.
[13] *Id*.
[14] *Id*.
[15] Section 61.13(2)(b), F.S.
[16] *See Mills v. Johnson*, 147 So. 3d 1023 (Fla. 2d DCA 2014) in which the trial court erred by adopting a timesharing schedule that did not address holiday timesharing given the historically contentious parenting relationship between the parties.
[17] *See generally Magdziak v. Sullivan*, 185 So. 3d 1291 (Fla. 5th DCA 2016); *see also Scudder v. Scudder*, 296 So. 3d 426 (Fla. 4th DCA 2020).
[18] Florida Supreme Court Approved Family Law Form 12.995(a), Parenting Plan (Feb. 2018), available at: https://www.flcourts.gov/content/download/686031/file_pdf/995a.pdf (last visited Mar. 26, 2025).

***Timesharing***

Under current law, a rebuttable presumption exists that equal time-sharing of a minor child is in the child's best interests.[19] As such, a court will start with the presumption that time-sharing should be divided equally (commonly referred to as "50/50") between both parents. However, either parent may rebut the presumption by proving that such equal-timesharing is not in the minor child's best interests.

To successfully overcome the presumption, the parent seeking to rebut the presumption must prove that 50/50 timesharing is not in the child's best interests by a preponderance of the evidence (that is, that the evidence presented is more convincing and likely true than the other parent's evidence, or in other words, meaning it's more probable than not). In establishing a timesharing schedule, except for when the parties agree to a schedule without court intervention, the court must consider the best interests of the child[20] and evaluate all "best interest"[21] factors.

When creating or modifying a time-sharing schedule, the court must evaluate all factors and must make specific written findings of fact related to each factor.[22]

***Court-Appointed Social Investigation and Study***

Section 61.20, F.S., provides authority for the court to order a "social investigation and study" in matters where the parenting plan is at issue. As such, a court may order a social investigation and study concerning all relevant details relating to the child and each parent in the case. Under Florida law, a social investigation and study may be ordered in any action where the parenting plan is at issue because the parents cannot agree and either:

- Such an investigation has not been done and, thus, a study has not been provided to the court by the parties; or
- The court determines that the investigation and study that have been done are insufficient.[23]

In a case where the court deems it necessary to order a social investigation and study, either the parties can jointly choose an investigator, or, if they are unable to agree, the court will select and appoint an investigator.[24] The social investigator must be qualified as an expert to testify regarding his or her written study.[25,26] The investigation and study must be conducted by:

- Qualified staff of the court;
- A child-placing agency licensed pursuant to s. 409.175, F.S.;
- A psychologist licensed under ch. 490, F.S.;
- A clinical social worker;
- A Marriage and Family therapist; or
- A mental health counselor licensed under ch. 491, F.S.[27]

[19] Section 61.13(2)(c)(1), F.S.
[20] Section 61.13(2)(c), F.S.
[21] Section 61.13(3), F.S.
[22] Section 61.13(2)(c)(1), F.S.
[23] Section 61.20(1), F.S.
[24] Fla. Fam. L.R.P. 12.364.
[25] *Id*.
[26] Section 90.702, F.S.
[27] Section 61.20(2), F.S.

Additionally, if a party is indigent and the court does not have qualified staff to perform the investigation and study, the court may request that the Department of Children and Family Services (DCF) conduct the study.[28]

When a social investigation and study is ordered, each party must be provided a copy of the report in advance of a hearing on the matter and must have an opportunity to review the report and offer evidence to rebut conclusions contained therein. [29] The Florida Family Law Rules of Procedure requires the written report to be provided to the parties no later than 30 days before trial.[30]

***Court Appointed Psychologist***

There are specific provisions related to court-appointed psychologists who are ordered to develop a parenting plan recommendation in a dissolution of marriage, domestic violence, or a paternity matter involving the relationship of a child and a parent.[31] Under current law, a court-appointed psychologist is presumed to be acting in good faith if his or her recommendation has been reached under standards that a reasonable psychologist would use to develop a parenting plan recommendation.[32]

Additionally, current law prohibits an administrative complaint against a court-appointed psychologist who acted in good faith from being filed anonymously. As such, a parent who wishes to file an administrative complaint against a court-appointed psychologist must include his or her name, address, and telephone number in the complaint.[33] However, current law does not require a parent to first seek to disqualify and replace the psychologist before he or she may file an administrative complaint against the psychologist.

Under current law, a parent who desires to file a legal action against such a court-appointed psychologist must petition the judge or presided over the underlying matter to appoint another psychologist.[34] If that parent establishes good cause for such an additional appointment, the court shall appoint another psychologist.[35] Current law provides for the award of two-way attorney fees in such a civil legal action dependent on whether the psychologist is found liable. As such, if, in a civil legal action against the psychologist, the psychologist is held not liable, the parent who brought the action is responsible for all reasonable costs and reasonable attorney fees associated with the action for the psychologist.[36] However, if the psychologist is held liable, he

[28] Section 61.20(2), F.S.
[29] *See Sacks v. Sacks*, 991 So. 2d 922 (Fla. 5th DCA 2008) (providing that parties must have a reasonable period of time prior to trial so that each can properly evaluate the report, undertake discovery, where appropriate, and have an adequate opportunity for preparation of rebuttal evidence; *see also Leinbach v. Leinbach*, 634 So. 2d 252, 253 (Fla. 2d DCA 1994) (providing that procedural due process prohibits a trial court from relying on a social investigation report to determine child custody without first providing the report to the parties and permitting them to introduce evidence that might rebut the conclusions or recommendations included in the report).
[30] Fla. Fam. L.R.P. 12.363(b).
[31] *See generally*, s. 61.122, F.S.
[32] Section 61.122(1), F.S.
[33] Section 61.122(2), F.S.
[34] Section 61.122(3), F.S.
[35] *Id*.
[36] Section 61.122(4), F.S.

or she will be responsible for and must pay all reasonable costs and attorney fees for the parent who brought the action.[37]

***Attorney Fees***

Historical Treatment of Attorney Fees

The traditional "English rule" entitled a prevailing party in civil litigation to attorney fees as a matter of right. However, Florida and a majority of other United States jurisdictions have adopted the "American rule," where each party bears its own attorney fees unless a "fee-shifting statute" provides an entitlement to fees. In Florida, several such fee-shifting statutes entitle the prevailing party or, more specifically, a particular prevailing claimant or plaintiff, to have his or her fees paid by the other party.[38]

Statutorily-Provided Attorney Fees

Several Florida and federal statutes state that a prevailing party in court proceedings is entitled to attorney fees as a matter of right.[39] These statutes are known as "fee-shifting statutes" and often entitle the prevailing party to a reasonable attorney fee, which must be paid by the other party. When a fee-shifting statute applies, the court must determine and calculate what constitutes a reasonable attorney fee. One such fee-shifting statute pertains to actions brought against court-appointed psychologists.[40]

Lodestar Approach

In 1985, the Florida Supreme Court held that courts should calculate the amount of statutorilyauthorized attorney fees under the "lodestar approach."[41] Under this approach, the first step is for the court to determine the number of hours reasonably expended by an attorney on the case. The second step requires the court to determine a reasonable hourly rate. The number of hours reasonably expended (determined in the first step), multiplied by the reasonable hourly rate (determined in the second step), produces the "lodestar amount," which is considered an objective basis for what the attorney fee amount should be.

***Administrative Complaint Process***

In Florida, certain professions and businesses are monitored by various agencies and departments. For example, a licensed attorney must be in good standing with the Florida Bar, and a disgruntled client may file a complaint with the Bar in relation to the attorney's representation

[37] Section 61.122(4), F.S.
[38] *See, e.g.*, s. 400.023, F.S. (nursing home resident); s. 440.34, F.S. (claimant in a workers' compensation case in certain situations); s. 501.2105, F.S. (plaintiff in specified FDUTPA actions); ss. 626.9373 and 627.428, F.S. (prevailing insured party in a case brought against an insurer); s. 790.33, F.S. (plaintiff in a suit to enforce his or her firearm rights); *see also* 42 U.S.C. s. 1988(b) (federal fee-shifting statute for prevailing parties in actions to enforce certain civil rights statutes).
[39] *See, e.g.*, s. 627.428, F.S. (providing that an insured who prevails against an insurer is entitled to "a reasonable sum" of attorney fees); s. 501.2105, F.S. (providing that the prevailing party in an action under the Florida Deceptive and Unfair Trade Practices Act (FDUTPA) is entitled to "a reasonable legal fee"); 42 U.S.C. s. 1988(b) (providing that a prevailing party seeking to enforce specified civil rights statutes may recover "a reasonable attorney's fee").
[40] Section 61.122(4), F.S.
[41] *Fla. Patient's Comp. Fund v. Rowe*, 472 So. 2d 1145 (Fla. 1985).
[42] Florida Department of Health, *Enforcement*, available at: https://www.floridahealth.gov/licensing-and-regulation/enforcement/index.html (last visited March 26, 2025).

of the client. Likewise, the Florida Department of Health (DOH) investigates complaints and reports involving healthcare providers and enforces applicable laws.[42] As such, DOH may take administrative action against providers under its purview including issuing reprimands, fines, restricting the practice of a specific provider, requiring remedial education, probation, license suspension or license revocation.[43] Depending on the severity of the allegation, a professional who is the subject of an administrative action may ultimately lose his or her license and be prohibited from practicing in the state if the complaint is determined to be verified and truthful.

The DOH does not charge a fee for anyone to file a complaint against a professional under its purview and the complaint remains confidential if probable cause is not found.[44] However, if probable cause is found, the complaint remains confidential until 10 days after such probable cause is found.[45]

The DOH currently licenses and regulates a large variety of healthcare professionals including medical doctors and psychologists.[46]

## III. Effect of Proposed Changes:

**Section 1** amends s. 61.122, F.S., to clarify that moving to disqualify a court-appointed psychologist is not a condition precedent to filing a supplemental legal action against the psychologist. The bill imposes a procedural condition precedent a parent must meet before he or she can file an administrative complaint against a court-appointed psychologist who was appointed to conduct a social investigation and study or make a parenting plan recommendation in a family law action. As such, a parent who wishes to file an administrative complaint against a court-ordered psychologist in relation to the psychologist's parenting plan recommendation must first move to disqualify the court-appointed psychologist from the family law proceeding before he or she can file an administrative complaint.

The bill requires a parent who wants to disqualify the selection of a court-appointed psychologist who has acted in good faith in developing a parenting plan recommendation to petition the judge presiding over the family law case to appoint a new, alternative psychologist in lieu of the originally appointed psychologist.

The bill also clarifies which party is responsible for paying certain attorney fees and costs in any supplemental legal action (that is, a separate legal action arising out of the underlying family law matter, not a pleading filed within the same case) against a court-appointed psychologist in his or her capacity as a court-appointed resource in a family law matter. The bill clarifies that the two-way attorney fee shifting structure outlined under current law applies to any additional or supplemental legal action against the court-appointed psychologist and does not apply as it relates to any hearings or filings in the underlying family law proceeding.

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[42] Florida Department of Health, *Enforcement*, available at: https://www.floridahealth.gov/licensing-and-regulation/enforcement/index.html (last visited March 26, 2025).
[43] *Id*.
[44] *Id*.
[45] *Id*.
[46] A complete list of the professions regulated under DOH can be found at https://www.floridahealth.gov/licensing-and-regulation/index.html.

The bill takes effect July 1, 2025.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The bill does not require cities and counties to expend funds or limit their authority to raise revenue or receive state-shared revenues as specified by Article VII, s. 18, of the State Constitution.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None Identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may have an indeterminate, yet insignificant, fiscal impact on local government for increases in workload associated with additional filings related to the disqualification of a court-appointed psychologist.

C. Government Sector Impact:

The bill will likely have an insignificant negative fiscal impact on the Department of Children and Families for increases in workload associated with additional filings related to the disqualification of a court-appointed psychologist. The costs can be absorbed within existing resources.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 61.122 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.)

**CS by Children, Families, and Elder Affairs on April 1, 2025:**

- Changes the title to "court-appointed psychologists;"
- Clarifies that moving to disqualify the psychologist is not a condition precedent to filing a supplemental legal action against the psychologist;
- Prohibits the filing of an administrative compliant before the complainant has moved to disqualify the court-appointed psychologist;
- Clarifies that a two-way attorney fee shifting provision applies in any supplemental legal actions against the psychologist; and
- Makes conforming and clean up language changes.

### B. Amendments:

None.

**By** the Committee on Children, Families, and Elder Affairs; and Senator Bernard

586-03170-25 2025976c1

A bill to be entitled

An act relating to court-appointed psychologists; amending s. 61.122, F.S.; requiring a party to seek disqualification of a court-appointed psychologist before filing an administrative complaint against the psychologist; providing for disqualification motions; revising provisions for award of costs and attorney fees in supplemental actions against court-appointed psychologists; providing an effective date.

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

Section 1. Subsections (2), (3), and (4) of section 61.122, Florida Statutes, are amended to read:

61.122 Parenting plan recommendation; presumption of psychologist's good faith; prerequisite to parent's filing suit; award of fees, costs, reimbursement.—

(2) An administrative complaint against a court-appointed psychologist which relates to a parenting plan recommendation conducted by the psychologist may not be filed anonymously. The individual who files an administrative complaint must include in the complaint his or her name, address, and telephone number. Such an administrative complaint may not be filed until the complainant has moved to disqualify the selection of the psychologist pursuant to subsection (3).

(3) A parent who desires to disqualify the selection of the ~~file a legal action against a~~ court-appointed psychologist or file an administrative complaint against the court-appointed psychologist who has acted in good faith in developing a







586-03170-25 2025976c1

parenting plan recommendation must petition the judge who is presiding ~~presided~~ over the dissolution of marriage, case of domestic violence, or paternity matter involving the relationship of a child and a parent, including time-sharing of children, to appoint an alternative ~~another~~ psychologist. Upon the parent's showing of good cause, the court shall appoint another psychologist. The court shall determine who is responsible for all court costs and attorney ~~attorney's~~ fees associated with making such an appointment.

(4) In any supplemental ~~If a~~ legal action~~, whether it be a civil action, a criminal action, or an administrative proceeding, is~~ filed against a court-appointed psychologist based upon his or her participation in a dissolution of marriage, case of domestic violence, or paternity matter involving the relationship of a child and a parent, including time-sharing of children, the claimant is responsible for all reasonable costs and reasonable attorney ~~attorney's~~ fees associated with the supplemental action for both parties if the psychologist is held not liable. If the psychologist is held liable in civil court, the psychologist must pay all reasonable costs and reasonable attorney's fees for the claimant.

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

The Florida Senate

# Committee Agenda Request

**To:** Senator Jay Trumbull, Chair
Appropriation Committee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** April 1, 2025

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I respectfully request that **Senate Bill #976**, relating to Court-appointed Social Investigators, be placed on the

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Mack Bernard

Senator Mack Bernard
Florida Senate, District 24

File signed original with committee office

S-020 (03/2004)

**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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1156 |
| INTRODUCER: | Health Policy Committee and Senator Harrell |
| SUBJECT: | Home Health Aide for Medically Fragile Children Program |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Looke | Brown | HP | **Fav/CS** |
| 2. | Barr | McKnight | AHS | **Favorable** |
| 3. | | | FP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 1156 amends laws relating to the Home Health Aide for Medically Fragile Children (HHAMFC) program. Specifically, the bill:

- Reduces 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.
- Specifies 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.
- Specifies that basic nursing skills training and clinical training must be specific to the child's care needs.
- Increases the Medicaid utilization cap from eight hours per day to 12 hours per day.
- Provides that the $25 per hour Medicaid reimbursement rate is a minimum rate.
- Requires 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] 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).

- 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.
- 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 bill has a significant negative fiscal impact to the Florida Medicaid program. **See Section V., Fiscal Impact Statement.**

The bill takes effect upon becoming a law.

## II. Present Situation:

### Home Health Aide for Medically Fragile Children Program

The Home Health Aide for Medically Fragile Children (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] While other Medicaid programs exist that compensate a family member who provides home health services to a Medicaid enrollee, the HHAMFC Program is the only one that compensates a family member who is not a licensed nurse, specifically for the provision of home health services to a medically fragile child.

The program allows a family caregiver to be reimbursed by Medicaid as an 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 be waiting to take the state licensing exam.[4]

The Agency for Health Care Administration (AHCA) is required to establish a Medicaid fee schedule to reimburse a home health agency for services provided by an HHAMFC at a rate of $25 per hour for up to 8 hours per day.[5]

[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, an 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.

An 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 an 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***

An 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 an 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 an 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 federal Centers for Medicare & Medicaid Services (CMS) conditions of participation, 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]

Federal 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 services 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.

***Medicaid Eligibility***

The Florida Department of Children and Families (DCF) 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:

**Section 1** amends s. 400.54, F.S., to require managed care plans to provide the Agency for Health Care Administration (AHCA) with data necessary to assess the rate and extent of hospitalizations for children attended by home health aides for medically fragile children (HHAMFC) compared with those attended by a registered nurse or licensed practical nurse. The AHCA is also required to include data on adverse incidents occurring under the care of an HHAMFC in the assessment.

The bill also requires home health agencies to report all adverse incidents occurring under the care of an 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.

**Section 2** amends s. 400.4765, F.S., related to the Home Health Aide for Medically Fragile Children (HHAMFC) program, to adjust the training requirements for an HHAMFC by:

- Eliminating the requirement that the training program consist of at least 85 hours of training;
- Reducing the required minimum number of hours of theoretical nursing instruction from 40 to 20;
- 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;
- Specifying that before providing services to an eligible relative, an 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; and
- Specifying 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.

The bill also modifies the Medicaid reimbursement schedule for HHAMFC services by:

- Increasing the utilization cap from eight hours per day to 12 hours per day. The bill specifies that if an 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.
- Providing that the $25 per hour reimbursement rate is a minimum rate.
  Additionally, the bill requires 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 an HHAMFC from the program must be disregarded when calculating eligibility for public assistance.[19]

**Section 3** amends s. 400.462(18), F.S., to make minor technical adjustments to the language for services to be provided by an HHAMFC.

**Section 4** 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.

**Section 5** 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 a law.

**Section 6** provides that the bill takes effect upon 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.

[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.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Agency for Health Care Administration indicates the required changes to the Medicaid fee schedule to establish $25 as the minimum rate and to increase the utilization cap from 8 hours to 12 hours per day will have a recurring fiscal impact on the Florida Medicaid program in the amount of $1.6 million ($0.7 million General Revenue).[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 Agency for Health Care Administration (AHCA) as part of the annual assessment reporting requirements for the home home health aide for medically fragile children (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 an 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.



[20] AHCA bill analysis for SB 1156, Feb. 27, 2025, (on file with Senate Health Policy Committee staff).

**By** the Committee on Health Policy; and Senator Harrell

588-03192-25 20251156c1

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.

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

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







588-03192-25 20251156c1

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)

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





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

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

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





made by this act to s. 400.4765, Florida Statutes.

Section 6. 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

April 3, 2025

Senator Trumbull
415 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 264 – Step-Therapy Protocols be placed on the next available agenda for the Health and Human Services Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, 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**

**THE FLORIDA SENATE**

Tallahassee, Florida 32399-1100

**SENATOR GAYLE HARRELL**
31st District

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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

April 3, 2025

Senator Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumble,

I respectfully request that SB 524 –New Born Screening be placed on the next available agenda for the Health and Human Services Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1156 –Home Health Aide for Medically Fragile Children be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1182 –Medicaid Coverage of Continuous Glucose Monitors be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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**SENATOR GAYLE HARRELL**
31st District

March 12, 2025

Senator Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1490 –Childrens Medical Services Program be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
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**President Pro Tempore**

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Higher Education, *Chair*
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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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1602 –Health Care Patient Protection be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

The Florida Senate

# APPEARANCE RECORD

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

4/10/2025
Meeting Date

Appropriations HHS
Committee

SB 1156
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: error ☒ 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

4/10/2025
Meeting Date

Appropriations Cmt on HHS
Committee

SB1560
Bill Number or Topic

Amendment Barcode (if applicable)

Name TANYA C. JACKSON

Phone 850-445-0107

Address 113 E. College Ave, 3rd Floor
Street

Email Tanya@PinPointResults.com

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:

☐ 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/CS/SB 1174 |
| INTRODUCER: | Appropriations Committee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senator Jones |
| SUBJECT: | Licensure of Family Foster Homes |
| DATE: | April 14, 2025 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Kennedy | Tuszynski | CF | **Fav/CS** |
| 2. | Sneed | McKnight | AHS | **Fav/CS** |
| 3. | | | RC | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/CS/SB 1174 amends the licensure requirements for family foster homes, residential child-caring agencies, and child-placing agencies allowing a foster parent to amend their current license when they relocate without the need to submit a new application.

The bill requires the Department of Children and Families (DCF) to adopt rules to streamline the licensure application process for family foster parents who are in good standing and relocate within the state, including prioritizing the review of their application, expediting home study and background checks, and recognizing prior foster parent training coursework.

The bill has no fiscal impact on state expenditures and revenues. **See Section V., Fiscal Impact Statement.**

The bill takes effect October 1, 2025.

## II. Present Situation:

### Florida's Child Welfare System – Generally

Chapter 39, F.S., creates Florida's dependency system charged with protecting children who have been abused, abandoned, or neglected. Florida's child welfare system identifies children

and families in need of services through reports to the central abuse hotline and child protective investigations. The Department of Children and Families (DCF) and community-based care (CBC) lead agencies work with those families to address the problems endangering children, if possible.[1] If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children.[2]

***Child Protective Investigations***

The DCF is required to operate and maintain a central abuse hotline (hotline)[3] to receive reports of known or suspected instances of child abuse[4], abandonment[5], or neglect[6], or instances when a child does not have a parent, legal custodian, or adult relative available to provide supervision and care.[7] The hotline must operate 24 hours a day, 7 days a week, and accept reports through a single statewide toll-free telephone number or through electronic reporting.[8]

If the hotline determines a report meets the statutory criteria for child abuse, abandonment, or neglect, a DCF child protective investigator (CPI) must complete a child protective investigation.[9] Through face-to-face interviews with the child and family members, and assessments of the immediate safety of the children in the home, the CPI determines further actions.

When a CPI determines that in-home services are not enough to ensure a child's safety, the CPI must remove the child from the home and place him or her in a safe and appropriate temporary out-of-home placement.[10] These placements are aimed to be the least restrictive, most family-like

[1] *See* Chapter 39, F.S.
[2] *Id.*
[3] Hereinafter cited as "hotline." The "Florida Abuse Hotline" is the DCF's central abuse reporting intake assessment center, which receives, and processes reports of known or suspected child abuse, neglect or abandonment 24 hours a day, seven days a week. Chapter 65C-30.001, F.A.C. and Section 39.101, F.S.
[4] Section 39.01(2), F.S. defines "abuse" as any willful act or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired.
[5] Section 39.01(1), F.S. defines "abandoned" or "abandonment" as a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both. "Establish or maintain a substantial and positive relationship" means, in part, frequent and regular contact with the child, and the exercise of parental rights and responsibilities.
[6] Section 39.01(53), F.S. states "neglect" occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired, except when such circumstances are caused primarily by financial inability unless services have been offered and rejected by such person.
[7] Section 39.201(1), F.S.
[8] Section 39.101(1), F.S.
[9] Prior to July 1, 2023, seven counties allowed the local sheriff's office to perform child protective investigations. The 2023 legislative session transitioned this responsibility fully back to the Department after changes in Florida's child welfare system aimed to integrate child protective investigations within existing crisis-oriented systems the DCF maintains. *See generally:* Laws of Fla. 2023-77.
[10] Section 39.4021, F.S.

placements available.[11] The DCF is required to consider a child's placement in the following priority order:[12]

- Nonoffending parent.
- Relative caregiver.
- Adoptive parent of the child's sibling, when the DCF or CBC lead agency is aware of such sibling.
- Fictive kin with a close existing relationship to the child.
- Nonrelative caregiver that does not have an existing relationship with the child.
- *Licensed foster care.*
- *Group or congregate care.*

If a child is removed from his or her home and placed in a family foster home, those foster parents become a critical place in a child's support network, ensuring their needs are met while in out-of-home placement and contributing to the potential reunification of the child with his or her biological family or some other permanency arrangement that is in the best interests of that child.[13]

**Licensure of Family Foster Homes**

Section 409.175, F.S. establishes the licensing requirements for family foster homes,[14] residential child-caring agencies,[15] and child-placing agencies,[16] with the purpose of protecting the health, safety, and well-being of children in such care.[17] Under existing law, family foster home licenses are issued for a specific person or agency at a specific location.[18]

Once issued, a family foster home license is non-transferable.[19]

[11] Section 39.4021, F.S.
[12] *Id.*
[13] *See* the Department of Children and Families, *Foster Care Overview*, available at: https://www.myflfamilies.com/services/child-family-services/foster-care/overview (last visited Mar. 6, 2025)
[14] Section 409.175(2)(e), F.S.; defined as a residence licensed by the department in which children who are unattended by a parent or legal guardian are provided 24-hour care. The term does not include an adoptive home that has been approved by the department or approved by a licensed child-placing agency for children placed for adoption.
[15] Section 409.175(2)(l), F.S.; defined as any person, corporation, or agency, public or private, other than the child's parent or legal guardian, that provides staffed 24-hour care for children in facilities maintained for that purpose, regardless of whether operated for profit or whether a fee is charged. Such residential child-caring agencies include, but are not limited to, maternity homes, runaway shelters, group homes that are administered by an agency, emergency shelters that are not in private residences, and wilderness camps. Residential child-caring agencies do not include hospitals, boarding schools, summer or recreation camps, nursing homes, or facilities operated by a governmental agency for the training, treatment, or secure care of delinquent youth, or facilities licensed under s. 393.067 or s. 394.875 or chapter 397.
[16] Section 409.175(2)(d), F.S.; defined as any person, corporation, or agency, public or private, other than the parent or legal guardian of the child or an intermediary acting pursuant to chapter 63, that receives a child for placement and places or arranges for the placement of a child in a family foster home, residential child-caring agency, or adoptive home.
[17] Section 409.175(1)(a), F.S.
[18] *See generally*, s. 409.175, F.S.
[19] Section 409.175(6)(i), F.S.

If a foster parent relocates, they are required to contact the DCF and their supervising agency in writing no less than 30 calendar days prior to the expected date of relocation.[20] Upon relocation, if relocating within the same region, the following is required of the foster parent:[21]

- New "Application for License to Provide Out-of-Home Care for Dependent Children;"
- New unified home study for the new location;
- Satisfactory environmental health inspection of the new residence;
- Disaster plan; and
- Home emergency evacuation plan.

If the foster parent is relocating between DCF regions, they must notify their supervising agency at least 30 days prior to the move. The coordination and responsibility for ensuring the transition of the license between regions is:[22]

- The supervising agency must assist the foster parent in finding a supervising agency in the new region.
- The CBC lead agency and supervising agency must work in partnership to secure a commitment from the new supervising agency to complete the requirements for licensing the new home.
- The new supervising agency must contact the foster parent within five business days of notification of the relocation to begin the licensing process.
- The DCF regional licensing office in the new region must request any additional documentation required to ensure that all minimum standards are met within 10 business days of receipt of the application file, and if no additional information is required, the new license shall be issued within 10 business days.

***Federal Law***

Title IV-E of the Social Security Act[23] mandates that all children in foster care are placed in safe and appropriate environments and that the child's health and safety shall be the paramount concern.[24] Furthermore, federal law mandates that the state is responsible for establishing and maintaining standards for foster family homes, including standards related to safety and sanitation.[25] State Title IV-E child welfare agencies ensure safe and appropriate environments by performing home studies to check the criminal backgrounds of the people and physical environments of the homes in which they place children.[26] Florida's approved federal Title IV-E state plan details how Florida meets the health and safety requirements of federal law, and this includes a unified home study of both foster and potential adoptive homes.[27]

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[20] Rule 65C-45.009(7), F.A.C.
[21] *Id.*
[22] Rule 65C-45.009(7), F.A.C.
[23] Title IV-E of the Social Security Act authorizes the federal-state Foster Care, Prevention, and Permanency program. Under this program states are entitled to federal reimbursement for a part of the cost of providing foster care to children who, typically, due to abuse or neglect in their own homes, are removed from that home and placed in foster care.
[24] 42 U.S. Code § 671; 45 CFR 1356.21(b)
[25] 42 U.S.C. 671(a)(10); 42 U.S. Code § 672
[26] *See generally*, Children's Bureau, *Home Study Requirements for Prospective Foster Parents*, available at https://www.childwelfare.gov/resources/home-study-requirements-prospective-foster-parents/ (last visited Mar. 8, 2025).
[27] *See Generally*, Agency Plan for Title IV-E of the Social Security Act, Foster Care and Adoption Assistance, State of Florida, available at https://www.myflfamilies.com/sites/default/files/2023-05/TitleIVEStatePlan-Approved01032020.pdf (last visited on Mar. 8, 2025); Child and Family Services Plan, 2025-2029, Department of Children and Families, available at

The DCF reports that without this home study of the physical location, the state could lose federal Title IV-E funding for foster care.[28]

## III. Effect of Proposed Changes:

The bill amends s. 409.175, F.S., to require the Department of Children and Families to adopt rules to streamline the licensure application process for a family foster parent who is in good standing and relocates within Florida. At a minimum, these rules must include the priority review of foster care applications, expedited home studies and background checks, and recognition of prior foster parent training coursework.

The bill takes effect 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:

None identified.

## V. Fiscal Impact Statement:

### A. Tax/Fee Issues:

None.

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https://www.myflfamilies.com/sites/default/files/2025-01/Child%20and%20Family%20Services%20Plan%202025-2029.pdf (last visited Mar. 9, 2025).

[28] Department of Children and Families, *2025 Agency Analysis*, pg.2 (on file with the Children, Families, and Elder Affairs Committee).

[28] *Id.*

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill has no fiscal impact on state expenditures or revenues.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill amends s. 409.175 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/CS by Appropriations Committee on Health and Human Services on April 10, 2025:**
The committee substitute:
- Clarifies that the Department of Children and Families (DCF) must adopt rules to streamline and prioritize the licensure application process for licensed foster parents who relocate within the state, including the priority review of foster care applications, expedited home studies and background checks, and recognition of prior foster parent training coursework.

**CS by Children, Families, and Elder Affairs on March 12, 2025:**
The CS makes the following changes:
- Reinserts language into statute keeping licenses nontransferable.
- Requires the DCF to adopt rules to ensure that a licensee that relocates can amend his or her current license without submitting a new application and that the licensure amendment process receives priority.

B. Amendments:

None.

166904

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/10/2025 | . | |
| | . | |
| | . | |
| | . | |

The Appropriations Committee on Health and Human Services (Jones) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 33 - 37

and insert:

2. The department shall adopt rules to streamline the licensure application process for a licensed foster parent who is in good standing and relocates within this state. These rules must include, but are not limited to, rules concerning priority review of applications, expedited home studies and background checks, and recognition of prior foster parent training

166904

coursework.

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

And the title is amended as follows:

Delete lines 4 - 7

and insert:

Children and Families to adopt rules to streamline the licensure application process for licensed foster parents who relocate within this state; requiring that such rules include priority review of applications, expedited home studies and background checks, and recognition of prior foster parent training coursework; providing an

**By** the Committee on Children, Families, and Elder Affairs; and Senator Jones

586-02323-25 20251174c1

A bill to be entitled

An act relating to licensure of family foster homes; amending s. 409.175, F.S.; requiring the Department of Children and Families to adopt rules to ensure that certain licensees may amend their licenses without submitting new applications and that the amended license process receives priority; providing an effective date.

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

Section 1. Paragraph (i) of subsection (6) of section 409.175, Florida Statutes, is amended to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(6)

(i)1. Upon determination that the applicant meets the state minimum licensing requirements and has obtained a letter from a community-based care lead agency which indicates that the family foster home meets the criteria established by the lead agency, the department shall issue a license without charge to a specific person or agency at a specific location. A license may be issued if all the screening materials have been timely submitted; however, a license may not be issued or renewed if any person at the home or agency has failed the required screening. The license is nontransferable. A copy of the license shall be displayed in a conspicuous place. Except as provided in paragraph (k), the license is valid for 1 year from the date of







586-02323-25 20251174c1

issuance, unless the license is suspended or revoked by the department or is voluntarily surrendered by the licensee. The license is the property of the department.

2. The department shall adopt rules to ensure that a licensee who moves to another location within this state may amend his or her current license without the need to submit a new application for licensure and that the amended license process receives priority.

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

The Florida Senate

# Committee Agenda Request

**To:** Senator Jay Trumbull, Chair
Appropriations Committee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** March 12, 2025

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I respectfully request that **Senate Bill #1174**, relating to Licensure of Family Foster Homes, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Shevrin D. "Shev" Jones
Florida Senate, District 34

File signed original with committee office

S-020 (03/2004)

**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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/CS/SB 1270 |
| INTRODUCER: | Appropriations Committee on Health and Human Services; Health Policy Committee; and Senator Collins |
| SUBJECT: | Department of Health |
| DATE: | April 14, 2025 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Smith/Looke | Brown | HP | **Fav/CS** |
| 2. | Gerbrandt | McKnight | AHS | **Fav/CS** |
| 3. | | | RC | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/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 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 to conform provisions of the Physical Therapy Licensure Compact model language by defining the term "party state."

The bill amends s. 766.1115, F.S., to add dental and 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 may have a significant, negative fiscal impact on the Division of Medical Quality Assurance (MQA). **See Section V., Fiscal Impact Statement.**

The bill takes effect 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:

### Department of Health

The Department of Health (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).[1] The DOH comprises a central state health office in Tallahassee, with statewide responsibilities; Florida's 67 county health departments (CHD); eight Children's Medical Services (CMS) area offices; 12 MQA regional offices; nine Disability Determinations regional offices; and three public health laboratories.[2]

[1] Section 20.42, F.S.
[2] Florida Department of Health, about the Florida Department of Health, *available at* https://www.floridahealth.gov/about/index.html (last visited Mar. 29, 2025).

The 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.[3] Professions are generally regulated by individual practice acts and by ch. 456, F.S., which provides regulatory and licensure authority for the MQA.

**Mobile Opportunity by Interstate Licensure Endorsement Act**

The Mobile Opportunity by Interstate Licensure Endorsement (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, the MQA has received 3,263 MOBILE applications and issued 769 licenses.[4]

**Temporary Certificates for Practice in Areas of Critical Need**

Both the Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) may issue temporary certificates to practice in areas of critical need to allopathic or osteopathic physicians and to allopathic and osteopathic physician assistants (PA) 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 (the boards collectively) are authorized to administer an abbreviated oral examination to determine a physician's or PAs competency. A written examination is not

[3] 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).
[4] Department of Health, Senate Bill 1270 *Legislative Analysis* (Mar. 11, 2025) (on file with the Senate Committee on Health Policy).
[5] Sections 458.315, and 459.0076, F.S.

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]

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] The BOM or BOOM 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, or admission to such 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.

[6] *Id.*
[7] Sections 458.315(3)(b) and 459.0076(3)(b), F.S.
[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.

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.

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 Vaccines***

Messenger Ribonucleic Acid (mRNA) 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 human immunodeficiency virus (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]

[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).

**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.

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 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***

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 the 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.[17]

**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:

[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 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 Advanced Practice Registered Nurse (APRN) or any facility which employs nurses to supply all or part of the care delivered.
- 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.

**Medical Marijuana Treatment Center and Certified Marijuana Testing Laboratory Requirements**

***Background Screening Requirements***

Because Medical Marijuana Treatment Centers (MMTC) and Certified Marijuana Testing Laboratories (CMTL) 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.

***Federal Bureau of Investigation 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,

[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.

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.[20] Failure to update statutory language could result in loss of 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.[21]

***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 actual 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** reenacts s. 381.00316(2)(g), F.S., to preserve the statutory definition of "messenger ribonucleic acid vaccine."[22] 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 messenger ribonucleic acid (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** 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** repeals section 9 of chapter 2023-43, L.O.F., which is the scheduled repeal of 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.

[20] 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).
[21] Department of Health, Senate Bill 1270 *Legislative Analysis* (Mar. 11, 2025) (on file with the Senate Committee on Health Policy).
[22] "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 4** amends s. 381.026, F.S., the Florida Patient's Bill of Rights and Responsibilities, to prohibit a health care provider[23] or health care facility[24] 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.

**Section 5** amends s. 381.986, F.S., to define, related to background screening requirements for Medical Marijuana Treatment Centers (MMTC), 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 an individual with the power or authority to direct or influence the direction or operation of an applicant or a MMTC through board membership, voting power, or a contract.
- "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 Department of Health (DOH) of the actual or attempted theft, diversion, or loss of marijuana by email.

**Section 6** amends s. 381.988, F.S., to define, related to background screening requirements for Certified Marijuana Testing Laboratories (CMTL), 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 an individual with the power or authority to direct or influence the direction or operation of an applicant or a MMTC through board membership, voting power, or a contract.

[23] "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.
[24] "Health care facility" means a facility licensed under chapter 395. *See* s. 381.026(2)(b), F.S.

- "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** 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** amend ss. 458.315 and 459.0076, F.S., to revise the standards for which the Board of Medicine and Board of 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** 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** 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.

The bill takes effect 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:

The bill may have a significant negative fiscal impact on the Division of Medical Quality Assurance (MQA) related to the revised criteria for licensure by endorsement (Section 7) and the issuance of certain temporary certificates (Sections 8 and 9). The MQA may experience a temporary increase in workload if rules need to be revised and systems updated to conform to provisions in the bill. It is likely that the costs can be absorbed within existing resources.

## 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/CS by Appropriations Committee on Health and Human Services on April 10, 2025:**
The committee substitute revises the definition of "manager" related to background screening requirements for medical marijuana treatment centers and certified marijuana testing laboratories to ensure compliance with the requirements for participation in the FBI's background check system established in Pub. L. 92-544.12.

**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 Physician's Assistants 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.

120352

LEGISLATIVE ACTION

| Senate | . | House |
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| 04/10/2025 | . | |
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The Appropriations Committee on Health and Human Services (Collins) recommended the following:

**Senate Amendment**

Delete lines 361 - 362

and insert:

applicant or a medical marijuana treatment center. The term includes an individual with the power or authority to direct or influence the direction or operation of an applicant or a medical marijuana treatment center through board membership, voting power, an agreement, or a contract.

120352

Delete lines 777 - 778

and insert:

certified marijuana testing laboratory. The term includes an individual with the power or authority to direct or influence the direction or operation of an applicant or a certified marijuana testing laboratory through board membership, voting power, an agreement, or a contract.

**By** the Committee on Health Policy; and Senator Collins

588-03159A-25 20251270c1

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 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.; 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. 381.988, F.S.; defining terms for purposes of background screening requirements for persons





**Florida Senate - 2025** **CS for SB 1270**

588-03159A-25 20251270c1

affiliated with medical marijuana testing laboratories; amending s. 456.0145, F.S.; revising eligibility criteria for licensure by endorsement 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. 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 pertaining to certain licensees in a certain system be available only to other party states; 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.

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

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:



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

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

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

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 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 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





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. 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 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.

Section 10. 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.

(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.

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 11. 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 12. 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.

**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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1354 |
| INTRODUCER: | Children, Families, and Elder Affairs Committee and Senator Trumbull |
| SUBJECT: | Behavioral Health Managing Entities |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Kennedy | Tuszynski | CF | **Fav/CS** |
| 2. | Sneed | McKnight | AHS | **Favorable** |
| 3. | | | FP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 1354 requires the Department of Children and Families (DCF) to contract for biennial operational and financial audits of behavioral health managing entities (MEs) that are charged with coordinating the state's safety net program for mental health and substance use disorder services for the uninsured and underinsured. A final report must be submitted to the Governor and Legislature by December 1, 2025.

The bill also establishes performance standards, requiring MEs to report on service accessibility, community behavioral health outcomes, diversion from acute care, and integration with child welfare services. MEs must track key behavioral health performance metrics, including high-utilizer rates, post-hospitalization outpatient care, appointment wait times, and emergency room visits for behavioral health issues. It requires the DCF to post ME performance information to its website by the 15th of every month.

The bill requires MEs to submit all required data to the DCF in a standardized electronic format to ensure interoperability and to facilitate data analysis.

The bill has a significant negative fiscal impact on state expenditures. **See Section V., Fiscal Impact Statement.**

This bill takes effect July 1, 2025.

## II. Present Situation:

### Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities can cope with normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- Emotional well-being: perceived life satisfaction, happiness, cheerfulness, peacefulness;
- Psychological well-being: self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- Social well-being: social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. More than one in five adults lives with a mental illness.[4] Young adults aged 18-25 had the highest prevalence of any mental illness[5] (36.2%) compared to adults aged 26-49 (29.4%) and aged 50 and older (16.8%).[6]

### *Mental Health Safety Net Services*

The Department of Children and Families (DCF) administers a statewide system of safety net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g., crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally established priority populations.

### Behavioral Health Managing Entities

In 2001, the Legislature authorized the DCF to implement behavioral health MEs as the management structure for the delivery of local mental health and substance abuse services.[7] The implementation of the ME system initially began as a pilot and, in 2008, the Legislature

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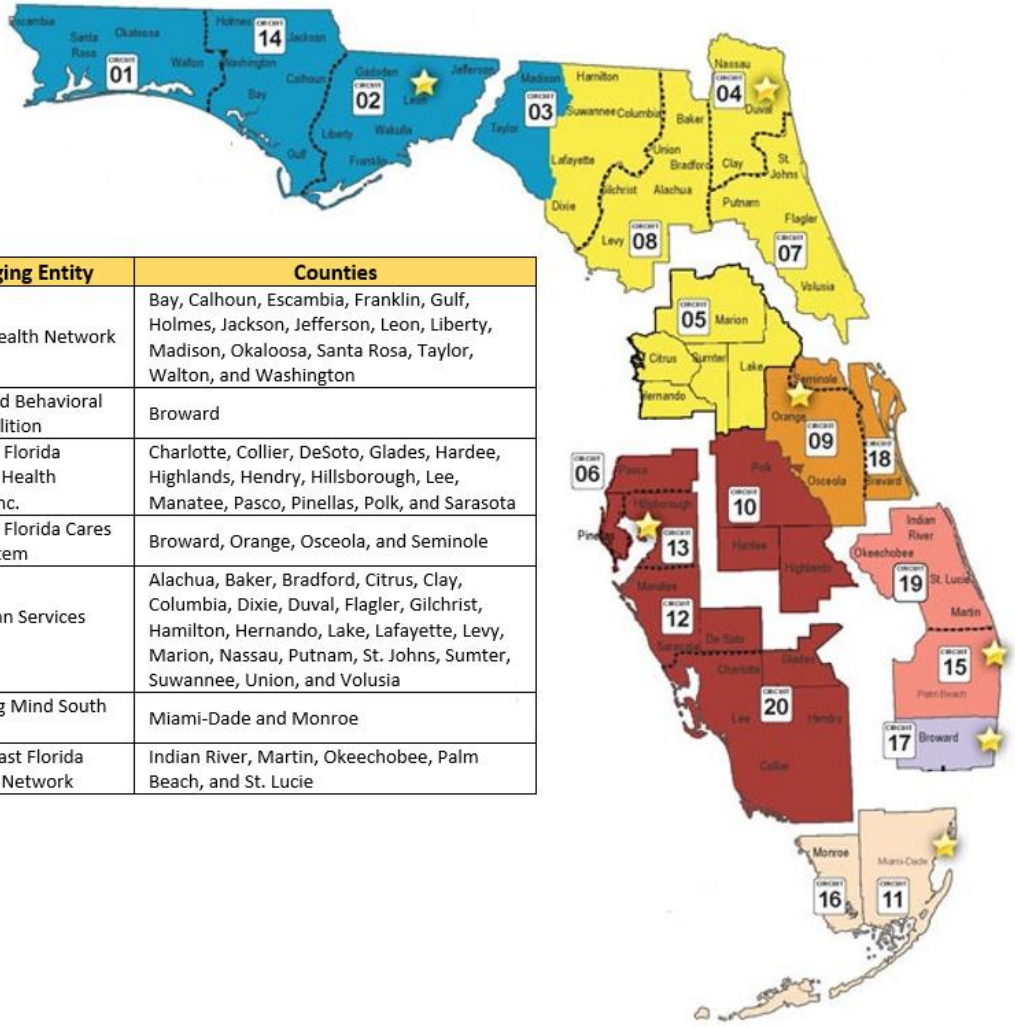
[1] World Health Organization, *Mental Health: Strengthening Our Response*, available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited March 7, 2025).
[2] Centers for Disease Control and Prevention, *Mental Health Basics*, available at: http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited March 7, 2025).
[3] *Id.*
[4] National Institute of Mental Health (NIH), *Mental Illness*, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited March 7, 2025).
[5] Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness).
[6] National Institute of Mental Health (NIH), *Mental Illness*, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited March 14, 2025).
[7] Ch. 2001-191, Laws of Fla.

authorized the DCF to implement MEs statewide.[8] MEs were fully implemented statewide in 2013, serving all geographic regions.

The DCF currently contracts with seven MEs for behavioral health services throughout the state. These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state. The regions are divided as follows:[9]




| Managing Entity | Counties |
|---|---|
| NWF Health Network | Bay, Calhoun, Escambia, Franklin, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Walton, and Washington |
| Broward Behavioral Health Coalition | Broward |
| Central Florida Behavioral Health Network, Inc. | Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota |
| Central Florida Cares Health System | Broward, Orange, Osceola, and Seminole |
| Lutheran Services Florida | Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia |
| Thriving Mind South Florida | Miami-Dade and Monroe |
| Southeast Florida Behavioral Network | Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie |

In the latest comprehensive, multiyear review of the revenues, expenditures, and financial positions of the MEs,[10] these contracts totaled $1.083 billion for Fiscal Year 2022-2023, with

[8] Ch. 2008-243, Laws of Fla.
[9] Department of Children and Families, *Managing Entities*, available at: https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited March 14, 2025).
[10] Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Positions of the Managing Entities Including a System of Care Analysis*, p. 5, available at https://myflfamilies.com/document/57451, (last visited March 21, 2025); Section 394.9082(4)(I), F.S.

$919 million spent on direct services.[11] MEs subcontract with community providers to serve clients directly. This allows services to be tailored to the specific behavioral health needs in the various regions of the state.[12]

In Fiscal Year 2022-2023, in the aggregate, the DCF reported serving 243,403 unduplicated behavioral health clients.[13]

***Coordinated System of Care***

The MEs are required to promote the development and implementation of a coordinated system of care.[14] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[15] A community or region provides a coordinated system of care for those with a mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, the DCF may award system improvements grants to MEs.[16] The MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in the DCF's assessment of behavioral health services in this state.[17] The DCF must use performance-based contracts to award grants.[18]

There are several essential elements which make up a coordinated system of care, including:[19]
- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:[20]
- Prevention services;
- Home-based services;

[11] Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Positions of the Managing Entities Including a System of Care Analysis*, p. 11, available at https://myflfamilies.com/document/57451, (last visited March 21, 2025); section 394.9082(4)(I), F.S.
[12] Department of Children and Families, *Managing Entities*, available at https://www.myflfamilies.com/services/samh/providers/managing-entities, (last visited March 16, 2025).
[13] S*upra*, Note 10, p. 14.
[14] Section 394.9082(5)(d), F.S.
[15] Section 394.4573(1)(c), F.S.
[16] Section 394.4573(3), F.S.
[17] *Id.*
[18] *Id.*
[19] Section 394.4573(2), F.S.
[20] Section 394.495(4), F.S.

- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

The DCF must define the priority populations which would benefit from receiving care coordination.[21] In defining priority populations, the DCF must consider the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.[22] The assessments must be submitted to the DCF for inclusion in the state and district substance abuse and mental health plan.[23] In addition to the needs assessment, the ME is generally required to also:

- Determine the optimal array of services to meet the community's needs.
- Promote a coordinated system of care.
- Assist counties in development of designated receiving systems and transportation plans.
- Develop strategies to divert persons with mental illness or substance abuse from criminal and juvenile justice systems and integrate behavioral health services with the child welfare system.
- Develop a compressive network of qualified providers to deliver services.
- Monitor network provider performance and compliance with contract requirements.[24]

Under Florida Administrative Code, MEs are required to implement a Care Coordination Policy applicable to all subcontracted service providers.[25] This policy must ensure that services are delivered based on eligibility, clinical appropriateness, individual need, and with fiscal accountability.[26] The rule requires care coordination policies that reduce, manage, and eliminate waitlists, support service planning for individuals with co-occurring substance use and mental

[21] Section 394.9082(3)(c), F.S.
[22] Section 394.9082(5)(b), F.S.
[23] Section 394.75(3), F.S.
[24] Section 394.9082(5), F.S.
[25] Rule 65E-14.014, F.A.C.
[26] *Id.*

health disorders and promote the use of clinical screening and assessment tools to determine the appropriate level of care. In addition, the policy must ensure that individuals are served in the least restrictive setting appropriate to their clinical needs and that system changes are monitored to improve service efficiency. The rule also calls for the use of outcome data to inform service delivery and to support continuous improvement across the behavioral health system.

**Data Collection and Reporting by Managing Entities**

MEs are responsible for collecting and reporting specific data to the DCF.[27] Current law requires MEs to establish performance standards related to:

- Service Reach: The extent to which individuals in the community receive services, including parents or caregivers involved in the child welfare system who need behavioral health services.
- Community Behavioral Health Improvement: The overall improvement in the behavioral health of the community.
- Individual Progress: The improvement in functioning or progress in recovery of individuals served by the ME, using person-centered measures tailored to the population.
- Diversion Strategies: The success of strategies to divert admissions from acute levels of care, jails, prisons, and forensic facilities, including metrics on clients experiencing multiple admissions to such facilities.
- Integration with Child Welfare: The effectiveness of integrating behavioral health services with the child welfare system.
- Housing Needs: Addressing the housing needs of individuals being released from public receiving facilities who are homeless.
- Consumer and Family Satisfaction: Levels of satisfaction among consumers and their families.
- Community Engagement: The level of engagement with key community constituencies, such as law enforcement agencies, community-based care lead agencies, juvenile justice agencies, courts, school districts, local government entities, hospitals, and other relevant organizations.

Florida Administrative Code further, establishes standards for service providers under direct contract with the DCF or subcontract with an ME.[28] It requires providers to report services using defined SAMH covered services and to adhere to specified measurement and reporting standards.

MEs are also required by contract to submit multiple reports, forms, and documents at specific intervals to the DCF.[29] Some of these include Regional Planning Documents, Provider Tangible Property Inventory, Triennial Needs Assessments, Managing Entity Annual Business Operations Plans (including Discharge Reintegration Plans upon exiting from mental receiving or treatment facilities, Triennial Needs Assessment, Care Coordination Plan, Quality Assurance Plan, Assisted Living Facility (ALF) - LMH Plan, Annual Network Service Provide Monitoring Plan), Enhancement Plan, Care Coordination Plan, Quality Assurance Plan, Fraud and Abuse

[27] Section 394.9082(7), F.S.
[28] Rule 65E-14.021, F.A.C.
[29] Department of Children and Families, Managing Entity Standard Contract, *Exhibit C3*, available at: https://www.myflfamilies.com/document/30496 (last visited March 21, 2025).

Prevention Protocol, Network Services Provider Monitoring Plan, Information Technology Plan, etc.[30]

MEs are also required by contract to submit multiple minimum performance measures.[31] This includes measures such as:

- On-site performance monitoring of network providers.
- Service level compliance.
- Federal block grant implementation.
- Network service provider measures.
- Corrective action for performance deficiencies.[32]

**Managing Entity Historic Funding**

The revenue for MEs largely consists of federal and state funds. State funds are derived from general revenue dollars appropriated to the DCF by the Legislature. Federal funds include sources that are dedicated to mental health and substance abuse services, including funds authorized by Title XIX, Part B of the Public Health Service Act through the Community Mental Health Block Grant and the Substance Use Prevention Treatment and Recovery Block (SUPTR) Grant. Both block grants include state maintenance of efforts requirements. The SUPTR includes set aside requirements for targeted services such as early intervention services for human immunodeficiency virus (HIV) and primary prevention activities. Other federal funds include the State Opioid Recovery (SOR) Grant awarded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (SAMHSA). The grant helps states provide prevention, harm reduction, treatment, to recovery support to individuals with substance use disorders, including opioid misuse.[33]

Other federal grants used to support Behavioral Health MEs include the Temporary Assistance for Needy Families (TANF) Block Grant authorized by Title IV-A of the Social Security Act, the Social Services Block Grant authorized by Title XX of the Social Security Act, and the State Children's Insurance Program authorized by Title XXI of the Medical Assistance Program.[34]

Managing Entity funding is categorized into administrative costs and operational costs. Funding for administrative costs is specifically appropriated in the General Appropriations Act.[35]

Collectively, MEs were appropriated $1.1 billion in Fiscal Year 2024-2025. The following table represents the total funds appropriated for the past six fiscal years.[36]

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[30] Department of Children and Families, Managing Entity Standard Contract, *Exhibit C3*, available at: https://www.myflfamilies.com/document/30496 (last visited March 21, 2025)..
[31] *Id*.
[32] *Id*.
[33] Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Positions of the Managing Entities Including a System of Care Analysis*, p. 26, available at https://myflfamilies.com/document/57451, (last visited April 7, 2025. Data excludes local funding projects.
[34] *Id*.
[35] Department of Children and Families, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Positions of the Managing Entities Including a System of Care Analysis*, p. 26, available at https://myflfamilies.com/document/57451, (last visited April 7, 2025.
[36] *Id*.

| BUDGET HISTORY | | | | | | |
|---|---|---|---|---|---|---|
| | FY 2019-20 | FY 2020-21 | FY 2021-22 | FY 2022-23 | FY 2023-24 | FY 2024-25 |
| Mental Health | 443,751,206 | 457,792,208 | 483,883,774 | 610,047,998 | 653,777,550 | 679,624,419 |
| Substance Abuse | 263,725,222 | 271,989,205 | 349,957,723 | 422,571,173 | 497,103,072 | 427279721 |
| Administration | 24,131,586 | 24,816,821 | 25,648,682 | 27,930,419 | 27,082,841 | 26,730,019 |
| **Total Budget** | **731,608,014** | **754,598,234** | **859,490,179** | **1,060,549,590** | **1,177,963,463** | **1,133,634,159** |

| EXPENDITURE HISTORY | | | | | |
|---|---|---|---|---|---|
| | FY 2019-20 | FY 2020-21 | FY 2021-22 | FY 2022-23 | FY 2023-24 |
| Mental Health | 429,754,117 | 420,879,474 | 447,800,378 | 551,890,303 | 613,298,595 |
| Substance Abuse | 244,637,813 | 253,620,477 | 301,064,371 | 365,093,486 | 434,165,262 |
| Administration | 22,065,970 | 21,788,325 | 21,782,757 | 24,047,102 | 22,702,292 |
| **Total Expenditures** | **696,457,900** | **696,288,276** | **770,647,506** | **941,030,891** | **1,070,166,149** |

## III. Effect of Proposed Changes:

**Section 1** amends s. 394.9082(3), F.S., to require the Department of Children and Families (DCF) to contract for biennial operational and financial audits of each managing entity (ME). The audits must include:

- Business practices, personnel, financial records, provider payments, expenditures, referral patterns, and provider network adequacy.
- Services administered, the method of provider payment, expenditures, outcomes, and other information as determined by the department.
- Referral patterns, including ME volume, provider assignments, services referred, length of time to obtain services, and key referral performance measures.
- Provider network adequacy and provider network participation in the DCF's available bed platform, the Opioid Data Management System, the Agency for Health Care Administration Event Notification Service, and other required provider data submissions.

The audits must review expenditures and claims of each ME, comparing services administered, outcomes, and Medicaid expenditures for behavioral health services and analyzing services funded by MEs rendered to individuals who are also Medicaid beneficiaries, to assess the extent to which MEs are funding Medicaid-covered services.

The audits must include recommendations to improve transparency of system performance, including metrics and criteria used to measure each ME's performance and patient and system outcomes, and the format and method used to collect and report data.

A final report summarizing audit findings and recommendations must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2025.

The bill amends s. 394.9082(5), F.S., to require an ME to submit all required information to the DCF in a standardized electronic format to ensure interoperability and facilitate data analysis. This format must meet the following criteria:

- Provider payments must be reported using a standardized format for electronic data interchange.

- Information organized into discrete, machine-readable data elements that allow for efficient processing and integration with other datasets.
- Comply with established protocols specified by the DCF.
- Compatible with automated systems to enable downloading, parsing, and combining data.
- Pass validation checks to confirm adherence to required data structure and format.

The bill requires MEs to submit all documents required under the contract for routine submission in an electronic format that supports accurate text recognition and data extraction. Documents must be accompanied by metadata to ensure proper organization, processing, and integration. This metadata must include the following:

- Descriptive and unique document name;
- Upload date;
- Predefined classification;
- Relevant identifiers; and
- Submitter information.

The bill amends s. 394.9082(7), F.S., to require MEs to collect and submit data on persons served, service outcomes, service costs, and other required data.

The DCF will evaluate ME performance and overall progress in meeting community behavioral health needs based on person-centered outcome measures that reflect national standards, where possible.

The bill requires MEs to submit the following new measures to the DCF:

- High Utilizers: The number and percentage of high utilizers of crisis behavioral health services.
- Post-Hospitalization Services: The number and percentage of individuals referred to outpatient behavioral health services within seven days after discharge from a receiving or treatment facility for behavioral health-related issues.
- Appointment Wait Times: The average wait time for initial appointments for behavioral health services, categorized by the type of service.
- Urgent Appointments: The number and percentage of individuals with significant behavioral health symptoms seeking urgent noncrisis acute care able to schedule urgent behavioral health appointments within one business day after initial contact with provider.
- Medication Errors: The number of incidences of medication errors.
- Adverse Incidents: The number and percentage of adverse incidents including, but not limited to, self-harm occurring during inpatient and outpatient behavioral health services.
- Co-occurring Conditions: the number of individuals receiving integrated care.
- Emergency Department Visits: The number and percentage of emergency department visits per capita for behavioral health-related issues.
- Community Discharge Placements: The percentage of individuals discharged from a receiving or treatment facility who successfully transition to ongoing services at the appropriate level of care.

- Emergency Department Readmissions: The rate of readmissions to an emergency department due to behavioral health issues or to crisis within 30 days of discharge from inpatient or outpatient behavioral health services.
- Average Length of Stay: The average length of stay for inpatient behavioral health services.

The bill takes effect July 1, 2025.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The bill does not require cities and counties to expend funds or limit their authority to raise revenue or receive state-shared revenues as specified by Article VII, s. 18, of the State Constitution.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None Identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

**Managing Entities and Community Providers**

The bill proposes expanded reporting and audit requirements based on claims processing. This likely does not align with current behavioral health managing entity (ME) funding and reporting systems, which do not rely on diagnosis-based or Medicaid billing structures. Additionally, the bill introduces new performance metrics and audit expectations that may exceed current data capabilities. Adapting to this model will likely require system updates, technical support, and staff training. The fiscal impact to MEs is indeterminate.

C. Government Sector Impact:

The bill requires the Department of Children and Families (DCF) to procure auditing services for the operational and financial audits of the contracted MEs. The DCF estimates recurring expenditures of $3 million for the procurement of auditing services.[37]

The current platform used by the DCF for managing mental health and substance abuse data is the Financial and Services Accountability Management System (FASAMS). According to the DCF, the data reporting provisions in CS/SB 1354 would necessitate extensive modifications to FASAMS.[38] The system changes will require platform integration, contractor resources, architecture changes, cloud storage, training, and professional services. The system upgrade is anticipated to take between 12 and 18 months to complete and is estimated to cost $6.9 million.[39]

| Resources Needed | Cost | Description |
|---|---|---|
| **IT Contractors (8)** | $1,920,000 | 8 contractors (data architects, developers, analysts, report developers) at $120/hour at 2,000 hours each = $240,000 per FTE |
| **Cloud Infrastructure & Security** | $800,000 | Hosting, cloud storage, cybersecurity measures |
| **Business Advisory & Project Management** | $1,500,000 | Oversight, requirement gathering, stakeholder engagement, risk management |
| **Training, OCM for MEs** | $700,000 | Training managing entities on new processes, data formats, portal usage |
| **Upgrading ME Systems** | $1,000,000 | Grants or funding assistance to help MEs modernize/replace legacy systems to ensure interoperability |
| **Additional Software, licensing's** | $1,000,000 | Integrates Edifecs with new portal, back-end APIs, data ingestion, and partner credentialing |
| **Total** | $6,920,000 | |

The new platform will require vendor support, infrastructure, training, and staffing to operate and maintain.[40] The additional recurring maintenance and operation costs are estimated to be $3.9 million.[41] This cost will not be incurred immediately, but is anticipated once the system updates are completed no earlier than Fiscal Year 2026-2027.

## VI. Technical Deficiencies:

None.

[37] Florida Department of Children and Families, *SB 1354 (2025) Agency Analysis*, March 7, 2025, p.7 (on file with the Children, Families, and Elder Affairs Committee).
[38] *Id*., p. 8
[39] *Id*, p. 9
[40] *Id*.
[41] *Id*.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 394.9082 of Florida Statute.

## 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 Children, Families, and Elder Affairs on March 25, 2025:**
The CS makes the following changes:

- Makes the operational and financial audits biennial instead of annual.
- Requires all currently reported data by managing entities (MEs) required by statute, rule, and contract to be submitted in an electronic format specified by the DCF.
- Requires the Department of Children and Families (DCF) to post ME performance information (based on the data collected) to its website by the 15th of every month.
- Generally, clarifies the data requested for evaluation for performance is data the MEs have access to, not general claims and private provider systems data as previously interpreted.

B. Amendments:

None.

**By** the Committee on Children, Families, and Elder Affairs; and Senator Trumbull

586-02853-25 20251354c1

A bill to be entitled

An act relating to behavioral health managing entities; amending s. 394.9082, F.S.; requiring the Department of Children and Families to contract biennially for specified functions; requiring the department to contract for recommendations for certain transparency improvements; requiring the department to prepare and present to the Governor and Legislature a specified final report by a specified date; requiring managing entities to report required data to the department in a standardized electronic format; providing requirements for such format; requiring managing entities to electronically submit to the department certain documents in a specified format and with specified metadata; requiring managing entities to submit certain specific measures to the department; requiring the department to post and maintain such measures on its website by a specified date every month; requiring managing entities to report each measure using a standard methodology determined by the department; providing requirements for such measures; providing an effective date.

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

Section 1. Subsection (7) of section 394.9082, Florida Statutes, is amended, and paragraph (n) is added to subsection (3) and paragraphs (v) and (w) are added to subsection (5) of that section, to read:







586-02853-25 20251354c1

394.9082 Behavioral health managing entities.—

(3) DEPARTMENT DUTIES.—The department shall:

(n)1. Contract for all of the following:

a. Biennial operational and financial audits of each managing entity to include all of the following:

(I) A review of business practices, personnel, financial records, related parties, compensation, and other areas as determined by the department.

(II) The services administered, the method of provider payment, expenditures, outcomes, and other information as determined by the department.

(III) Referral patterns, including managing entity referral volume; provider referral assignments; services referred; length of time to obtain services; and key referral performance measures.

(IV) Provider network adequacy and provider network participation in the department's available bed platform, the Opioid Data Management System, the Agency for Health Care Administration Event Notification Service, and other department-required provider data submissions.

(V) Audits of each managing entity's expenditures and claims. Such an audit must do both of the following:

(A) Compare services administered through each managing entity, the outcomes of each managing entity's expenditures, each managing entity's Medicaid expenditures for behavioral health services, and any other information as determined by the department.

(B) Analyze services funded by each managing entity rendered to individuals who are also Medicaid beneficiaries to,

at a minimum, assess the extent to which managing entities are funding services that are also available as covered services under the Medicaid program.

b. Recommendations to improve transparency of system performance, including, but not limited to, metrics and criteria used to measure each managing entity's performance and patient and system outcomes, and the format and method to be used to collect and report necessary data and information.

2. Prepare a report of the information gathered in subparagraph 1. and present the final report on or before December 1, 2025, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(5) MANAGING ENTITY DUTIES.—A managing entity shall:

(v) Report all required data to the department in a standardized electronic format to ensure interoperability and to facilitate data analysis. The submission format must meet all of the following criteria:

1. Provider payments must be reported using a standardized format for electronic data interchange that is used for health care claims processing.

2. Information must be organized into discrete, machine-readable data elements that allow for efficient processing and integration with other datasets.

3. All data fields must comply with established protocols as specified by the department.

4. The standardized format must be compatible with automated systems to enable the downloading, parsing, and combining of data with other sources for analysis.

5. Submissions must pass validation checks to confirm





adherence to the required data structure and format before the submission is accepted.

(w) Submit to the department all documents that are required under contract for submission on a routine basis in an electronic format that allows for accurate text recognition and data extraction as specified by the department, which may include, but is not limited to, Portable Document Format or machine-readable text files. The documents must be accompanied by metadata containing key information that ensures proper organization, processing, and integration into the department's systems. The required metadata must include, but is not limited to, all of the following elements:

1. A descriptive and unique name for the document, following any naming conventions prescribed by the department.

2. The date the document is uploaded.

3. A predefined classification indicating the nature or category of the document.

4. Any relevant identifiers, such as application numbers, case numbers, or tracking codes, as specified by the department.

5. The name, contact information, and any other required identification number, which may include, but is not limited to, a contract, license, or registration number, of the person or organization submitting the document.

6. Any other metadata fields as prescribed by the department to facilitate accurate processing and analysis.

(7) PERFORMANCE MEASUREMENT AND ACCOUNTABILITY.—

(a) Managing entities shall collect and submit data to the department regarding persons served, outcomes of persons served, costs of services provided through the department's contract,

and other data as required by the department. The department shall evaluate managing entity performance and the overall progress made by the managing entity, together with other systems, in meeting the community's behavioral health needs, based on consumer-centered outcome measures that reflect national standards, if possible, that can be accurately measured. The department shall work with managing entities to establish performance standards, including, but not limited to:

1.~~(a)~~ The extent to which individuals in the community receive services, including, but not limited to, parents or caregivers involved in the child welfare system who need behavioral health services.

2.~~(b)~~ The improvement in the overall behavioral health of a community.

3.~~(c)~~ The improvement in functioning or progress in the recovery of individuals served by the managing entity, as determined using person-centered measures tailored to the population.

4.~~(d)~~ The success of strategies to:

a.~~1.~~ Divert admissions from acute levels of care, jails, prisons, and forensic facilities as measured by, at a minimum, the total number and percentage of clients who, during a specified period, experience multiple admissions to acute levels of care, jails, prisons, or forensic facilities;

b.~~2.~~ Integrate behavioral health services with the child welfare system; and

c.~~3.~~ Address the housing needs of individuals being released from public receiving facilities who are homeless.

5.~~(e)~~ Consumer and family satisfaction.





6.~~(f)~~ The level of engagement of key community constituencies, such as law enforcement agencies, community-based care lead agencies, juvenile justice agencies, the courts, school districts, local government entities, hospitals, and other organizations, as appropriate, for the geographical service area of the managing entity.

(b) Managing entities must submit specific measures to the department regarding individual outcomes and system functioning, which the department must post to, and maintain on, its website by the 15th of every month. The posted measures must reflect performance for the previous calendar month. Each managing entity must report each measure using a standard methodology determined by the department and submit the data to the department by the deadline specified by the department. The measures shall include data from individuals served by each managing entity for services funded by the managing entity, to the extent feasible and appropriate. The measures shall be reported and posted stratified by, at a minimum, whether the individual is a child or an adult and whether the individual is a Medicaid recipient. Such measures shall include, at a minimum, all of the following:

1. The number and percentage of individuals who are high utilizers of crisis behavioral health services.

2. The number and percentage of individuals referred to outpatient behavioral health services after their discharge from a receiving or treatment facility, an emergency department under this chapter, or an inpatient or residential licensed service component under chapter 397 and who begin receiving such services within 7 days after discharge.

3. The average wait time for initial appointments for behavioral health services, categorized by the type of service.

4. The number and percentage of individuals with significant behavioral health symptoms who are seeking urgent but noncrisis acute care and who are scheduled to be seen by a provider within 1 business day after initial contact with the provider.

5. The number and percentage of emergency department visits per capita for behavioral health-related issues.

6. The incidence of medication errors.

7. The number and percentage of adverse incidents, including, but not limited to, self-harm, occurring during inpatient and outpatient behavioral health services.

8. The number and percentage of individuals with co-occurring conditions who receive integrated care.

9. The number and percentage of individuals discharged from a receiving or treatment facility under this chapter or an inpatient or residential licensed service component under chapter 397 who successfully transition to ongoing services at the appropriate level of care.

10. The rate of readmissions to emergency departments due to behavioral health issues or to crisis stabilization units, addictions receiving facilities, or other inpatient levels of care under this chapter and chapter 397 within 30 days after discharge from inpatient or outpatient behavioral health services.

11. The average length of stay for inpatient behavioral health services.

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

**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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | SB 1412 |
| INTRODUCER: | Senator Calatayud |
| SUBJECT: | Home Health Care Services |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Looke | Brown | HP | **Favorable** |
| 2. | Barr | McKnight | AHS | **Favorable** |
| 3. | | | RC | |

## I. Summary:


SB 1412 amends laws related to home health agencies (HHA). Specifically, the bill:

- Allows one administrator to manage multiple HHAs with identical controlling interests, regardless of where they are located;
- Removes 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
- Reworks the Excellence in Home Health Program to require the Agency for Health Care Administration to adopt standards that are adaptable to all types of HHAs, regardless of payor type, patient population, or service designations.

The bill has no fiscal impact on state expenditures or revenues. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.


## II. Present Situation:

### Home Health Agencies

A home health agency (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

[1] Section 400.462, F.S.

- Medical supplies.[2]

HHAs are licensed and regulated by the Agency for Health Care Administration. 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. 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 an 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]

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[2] Section 400.462, F.S.
[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. 2
[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. 2
[8] Section 400.487, F.S.
[9] *Id*.
[10] *Supra* n. 2
[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:

**Section 1** amends s. 400.476, F.S., to allow a home health agency (HHA) administrator to manage multiple HHAs regardless of their location as long as they have identical controlling interests.

**Section 2** amends s. 400.487, F.S., to remove a requirement that, when nursing services are ordered, a direct employee of the HHA to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit. The bill requires nursing services provided by direct employees to a HHA be monitored and managed by the admitting HHA.

**Section 3** amends s. 400.52, F.S., to rework the Excellence in Home Health Program to require that the Agency for Health Care Administration adopt standards that are adaptable to all types of

[12] Section 400.52, F.S.

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:

- Patient or client satisfaction, including communication and willingness to recommend the HHA.
- Service excellence, including:
  - For skilled providers – outcomes related to clinical improvements, such as reducing adverse events, unplanned emergency care, and hospitalizations.
  - For nonskilled providers – contributions to daily living support, personal care quality, and overall client well-being.
- 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.

**Section 4** provides that the bill takes effect 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 bill requires the Agency for Health Care Administration (AHCA) to rework the standards for the Excellence in Home Health Program and modify Rule 59A-8.0248, Excellence in Home Health. The AHCA can absorb the requirement within existing resources.

## 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.

**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







38-01268-25 20251412__

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.

The Florida Senate

# APPEARANCE RECORD

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

4/10/2025
Meeting Date

Appropriations HHS
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**

# 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/CS/SB 1490 |
| INTRODUCER: | Appropriations Committee on Health and Human Services; Health Policy Committee; and Senator Harrell |
| SUBJECT: | Children's Medical Services Program |
| DATE: | April 14, 2025 |
| REVISED: | |

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

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/CS/SB 1490 transfers the operation of the Children's Medical Services (CMS) Managed Care Plan from the Department of Health (DOH) to the 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 nursing 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 December 31, 2025, detailing certain aspects of the waiver redesign.

The bill will have no fiscal impact on state expenditures. **See Section V., Fiscal Impact Statement.**

The bill takes effect upon becoming a law, except as otherwise expressly provided.

## II. Present Situation:

### Florida Agency for Health Care Administration

The 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 $33 billion Medicaid program (which is projected to serve 4.2 million Floridians in state fiscal year 2024-2025)[2], 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.[3]

### 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.[4] 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.[5]

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

[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* 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] Social Services Estimating Conference, *Medicaid Caseloads and Expenditures, February 12, 35 and 27, 2025, Executive Summary available at* https://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf (last visited Apr. 4, 2025).
[3] 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).
[4] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid (last visited Mar. 30, 2025).
[5] Section 20.42, F.S.

covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.[6]

**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[7] and the Florida Healthy Kids Corporation, a non-profit organization, form the Florida KidCare partnership. MediKids, Florida Healthy Kids, and Title XXI Children's Medical Services (CMS) Managed Care Plan compose Florida KidCare. Florida KidCare is not an entitlement program, and the families pay a monthly premium that varies depending on the family's income. Florida KidCare also includes Medicaid for children.[8]

**Statewide Medicaid Managed Care**

Approximately 72.5 percent of Florida Medicaid recipients[9] receive services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[10] The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and the Prepaid Dental Health program.[11] 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.[12]

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.[13] In 2020, the Legislature extended the allowable term of the SMMC contracts from five to six years.[14] As a result, the AHCA's previous contracts

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[6] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid-state-planamendments/index.html (last visited Mar. 30, 2025).
[7] The Agency for Health Care Administration, the Department of Children and Families, and the Department of Health.
[8] 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).
[9] 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; Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[10] 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).
[11] 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).
[12] Agency for Health Care Administration, *Senate Bill 1490* (Nov. 4, 2024) (on file with Senate Committee on Health Policy).
[13] 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).
[14] Chapter 2020-156, s. 44, Laws of Florida.

recently ended in December 2024. On February 1, 2025, the AHCA implemented new SMMC contracts, and the contractual period runs through 2030.[15]

**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,[16,17] Florida's current Medicaid waivers are as follows:[18]

- Section 1115 – Research & Demonstration Projects[19]
  - 1115 Florida MMA Waiver[20]
  - 1115 Florida Medicaid Family Planning Waiver[21]
- Section 1915(b) – Managed Care Waivers[22]
  - 1915(b)(1)(4) Florida Non-Emergency Transportation (NET) Waiver[23]

[15] 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).
[16] Medicaid.gov, *Managed Care Authorities, available at* https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities (last visited Mar. 30, 2025).
[17] 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).
[18] Agency for Health Care Administration, *2025 Agency Legislative Bill Analysis – Senate Bill 1490* (Nov. 4, 2024) (on file with Senate Committee on Health Policy).
[19] 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).
[20] 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 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] 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* 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).
[22] 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).
[23] The Florida NET waiver provides NET services to eligible Medicaid recipients; see 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).

- Concurrent Section 1915(b) and 1915(c)[24] Waivers
  - 1915(b)(c) Florida LTC Managed Care Waiver[25]
- Concurrent Section 1915(a)[26] and 1915(c) Waivers
  - 1915(a)(c) Florida Comprehensive Intellectual and Developmental Disabilities Managed Care (IDD Pilot) Waiver[27]
- Section 1915(c) – Home and Community Based Services (HCBS) Waivers
  - 1915(c) Florida Developmental Disabilities Individual Budgeting (iBudget) Waiver[28]
  - 1915(c) Florida Familial Dysautonomia (FD) Waiver[29]
  - 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").[30]

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[24] 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).

[25] 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* 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).

[26] 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).

[27] The IDD Pilot Waiver is a voluntary, comprehensive program consisting of MMA, LTC waiver, and Florida Developmental Disabilities Individual Budgeting (iBudget) waiver services; *see* 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).

[28] 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* 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).

[29] 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* 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).

[30] Agency for Health Care Administration, *Medicaid 2025 General Session CMS Transfer Briefing* (Feb. 19, 2025) (on file with Senate Committee on Health Policy).

The current eligibility criteria for the Model waiver require that eligible individuals must be:[31]

- 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
- 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 services who do not have degenerative spinocerebellar disease.[32] Model waiver services include environmental accessibility adaptations, nursing home transition services, and respite care.[33]

**Services to Medically Fragile Children**

Private Duty Nursing (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.[34] Under the Florida Medicaid PDN and Family Home Health Aide Services Coverage Policy,[35] 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

[31] 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).
[32] 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* 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).
[33] Agency for Health Care Administration, *Medicaid 2025 General Session CMS Transfer Briefing* (Feb. 19, 2025) (on file with Senate Committee on Health Policy).
[34] *Supra* note 32.
[35] 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).

amended Rule 59G-4.261, F.A.C., Florida Medicaid PDN and Family Home Health Aide Services, effective October 1, 2024.[36]

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:[37]

- 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
- 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.[38]

Under the state plan, Florida Medicaid does not currently offer children receiving PDN services respite or home modifications.[39]

**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.[40]

**The DOH's Division of Children's Medical Services**

The DOH's Division of CMS is a collection of programs serving children with special health care needs, including the:

- Child Abuse Death Review Unit;[41]
- Child Protection Teams;[42]
- CMS Managed Care Plan;

[36] Agency for Health Care Administration, *Medicaid 2025 General Session CMS Transfer Briefing* (Feb. 19, 2025) (on file with Senate Committee on Health Policy).
[37] Agency for Health Care Administration, *Medicaid 2025 General Session CMS Transfer Briefing* (Feb. 19, 2025) (on file with Senate Committee on Health Policy).
[38] *Id*.
[39] *Id*.
[40] Section 381.001, F.S.
[41] 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* 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.
[42] 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 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).

- Children's Multidisciplinary Assessment Team;[43]
- Early Steps;[44]
- Medical Foster Care Program;[45]
- Newborn Screening Program;[46]
- Poison Information Center Network;[47]
- Regional Perinatal Intensive Care Centers Program;[48]
- Safety Net Program;[49]
- Sexual Abuse Treatment Program;[50] and

[43] 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* 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).

[44] 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* 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).

[45] 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 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).

[46] 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).

[47] 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 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).

[48] 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 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).

[49] 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* 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).

[50] 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 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).

- Title V Program.[51]

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[52] for Florida KidCare and Medicaid.[53]

***The CMS Managed Care Plan***

The CMS Network[54] 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 a fee-for-service program serving children with special health care needs who were enrolled in either Medicaid or Florida KidCare.[55]

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[56] 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.[57]

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

[51] 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 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).
[52] "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.
[53] Part I, of ch. 391, F.S.
[54] "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.
[55] Agency for Health Care Administration, *2025 Agency Legislative Bill Analysis – Senate Bill 1490* (Nov. 4, 2024) (on file with Senate Committee on Health Policy).
[56] 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* 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.
[57] *Supra* note 54.

from the CMS Network to the CMS Managed Care Plan; however, the word "network" is used interchangeably with the CMS Managed Care Plan.[58]

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.[59]

## III. Effect of Proposed Changes:

**Section 1** transfers 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 (DOH) Children's Medical Services (CMS) Managed Care Plan to the Agency for Health Care Administration (AHCA) effective July 1, 2025.

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 the Children's Health Insurance Program (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** requires 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 also 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, the following:

[58] Agency for Health Care Administration, *2025 Agency Legislative Bill Analysis – Senate Bill 1490* (Nov. 4, 2024) (on file with Senate Committee on Health Policy).
[59] *Id*.

- 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 Children's Multidisciplinary Assessment Team; 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:
- Updates statute 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 Department of Children and Families 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** repeals subsections 391.026(8)-(11), F.S., effective July 1, 2025.

**Section 8** repeals s. 391.028, F.S., effective July 1, 2025, to delete the following:
- The requirement providing that the Director of the DOH CMS program 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 DOH CMS program are related to the regional perinatal intensive care centers. The bill updates the provisions related to eligibility for the DOH 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 also deletes the requirement that the Florida Birth-Related Neurological Injury Compensation Association[60] reimburse the CMS Network the state's share of funding to obtain matching federal funds under CHIP.

**Section 10** requires 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 DOH is authorized to offer additional benefits through the components of the CMS program.

The bill repeals this section of statute on January 1, 2026.

**Section 11** repeals s. 391.035, F.S., relating to CMS provider qualifications.

**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.

[60] 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 17** deletes 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** repeals 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[61] by the Florida Office of Insurance Regulation (OIR)[62] 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)[63] 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,

[61] 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).
[62] 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).
[63] 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).

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** requires 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 private duty nursing (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 Statewide Medicaid Managed Care (SMMC) plans. The AHCA is authorized to contract with necessary experts to assist in developing the plan.

The bill also requires the AHCA submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 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 a 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, s. 6 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 proposed transfer of staff from the Department of Health's Division of Children's Medical Services to the Agency for Health Care Administration is budget neutral.

## VI. Technical Deficiencies:

Under s. 409.166(4)(f), F.S., the Department of Children and Families 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, Children's Medical Services (CMS), or Children's Mental Health Services. As the bill is written, it is unclear whether "Children's Medical Services" 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 Children's Medical Services (CMS) program operational issues and confusion:

- Section 6 of the bill deletes the requirement that the Department of Health (DOH) maintain program integrity in the CMS program.
- 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/CS by Appropriations Committee on Health and Human Services on April 10, 2025:**
The committee substitute revises the due date from September 30, 2025, to December 31, 2025, for the study of a redesign of the Florida Medicaid Model Waiver required in Section 32 of the underlying 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 Agency for Health Care Administration (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.

649872

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/10/2025 | . | |
| | . | |
| | . | |
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The Appropriations Committee on Health and Human Services (Harrell) recommended the following:

**Senate Amendment**

Delete line 643

and insert:

House of Representatives by December 31, 2025, addressing, at a

**By** the Committee on Health Policy; and Senator Harrell

588-03165-25 20251490c1

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. 409.974, 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







588-03165-25 20251490c1

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; 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 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 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. 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 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 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.

(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 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.

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 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:

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:

~~(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 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 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 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 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~~.

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 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 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.

Section 33. Except as otherwise expressly provided in this act, 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

April 3, 2025

Senator Trumbull
415 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 264 – Step-Therapy Protocols be placed on the next available agenda for the Health and Human Services Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, 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**

**THE FLORIDA SENATE**

Tallahassee, Florida 32399-1100

**SENATOR GAYLE HARRELL**
31st District

**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

April 3, 2025

Senator Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumble,

I respectfully request that SB 524 –New Born Screening be placed on the next available agenda for the Health and Human Services Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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Education Postsecondary
Environment and Natural Resources
Rules

**SENATOR GAYLE HARRELL**
31st District

March 12, 2025

Senator Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1156 –Home Health Aide for Medically Fragile Children be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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**President Pro Tempore**

**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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1182 –Medicaid Coverage of Continuous Glucose Monitors be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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**THE FLORIDA SENATE**

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Appropriations Committee on Higher Education, *Chair*
Health Policy, *Vice Chair*
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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 Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1490 –Childrens Medical Services Program be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
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**BEN ALBRITTON**
**President of the Senate**

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THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

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Appropriations Committee on Higher Education, *Chair*
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Appropriations Committee on Health and Human Services
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Environment and Natural Resources
Rules

**SENATOR GAYLE HARRELL**
31st District

March 12, 2025

Senator Trumbull
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Trumbull,

I respectfully request that SB 1602 –Health Care Patient Protection be placed on the next available agenda for the Health and Human Appropriations Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 31

Cc: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

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**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

The Florida Senate

# APPEARANCE RECORD

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

April 9, 2025
Meeting Date

Appropriations Committee on Health and Human Services
Committee

CS/SB 1490
Bill Number or Topic

Amendment Barcode (if applicable)

Name Brian Meyer, AHCA Deputy Secretary of Medicaid

Phone (850) 412-3611

Address 2727 Mahan Drive, Building 3, Room 3132
*Street*

Email LegAffairs@AHCA.MyFlorida.com

Tallahassee — *City*
FL — *State*
32308 — *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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1568 |
| INTRODUCER: | Appropriations Committee on Health and Human Services and Senator Brodeur |
| SUBJECT: | Electronic Prescribing |
| DATE: | April 14, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Smith | Brown | HP | **Favorable** |
| 2. | Gerbrandt | McKnight | AHS | **Fav/CS** |
| 3. | | | RC | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 1568 revises exceptions to Florida's electronic prescribing (e-prescribing) requirement. Authorized prescribers who prescribe a medicinal drug in their capacity as an owner, employee, or contractor of a health care facility or practice that maintains an electronic health records system must electronically transmit prescriptions instead of issuing written prescriptions, unless they meet an exception.

The bill lists exceptions for prescribers who:

- Prescribe fewer than 100 prescriptions annually.
- Are located in an area where a state of emergency has been declared.
- Have been issued a waiver by the Department of Health due to circumstances beyond their control.
- Determine that it would be impractical for the patient to obtain a medicinal drug prescribed by electronic prescription in a timely manner.
- Are experiencing a temporary technological or electrical failure.
- Are issuing a prescription to an individual receiving hospice care.
- Determine, or the patient determines for himself or herself, that it is in the best interest of the patient to compare prescription drug prices among area pharmacies.

The bill removes several exceptions from current law. Prescribers who no longer qualify for an exception would be required to establish compliance with the e-prescribing requirement upon their next scheduled license renewal or by July 1, 2026, whichever occurs first.

The bill purports to align Florida's exceptions to e-prescribing requirements for *all* prescription drugs with federal exceptions that apply only to controlled substances under Medicare Part D. [1] However, federal law includes additional provisions, such as a compliance threshold of 70 percent, which the federal Centers for Medicare & Medicaid Services (CMS) is expected to review and revise.[2]

A prescriber prescribing in a personal capacity and not as an owner, employee, or contractor of a facility or practice that maintains an electronic health records system remains exempt from e-prescribing requirements under the bill.

The bill has an insignificant, negative fiscal impact on state expenditures that can be absorbed within existing resources. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

### E-prescribing

E-prescribing refers to the transmission of prescription information in electronic format from a prescriber at the point of care to a pharmacy. It is widely adopted as a method to improve the accuracy and legibility of prescriptions, reduce medication errors associated with handwritten or phoned-in orders, prevent prescription fraud and forgery, and streamline the medication dispensing process. In provider settings, e-prescribing integrates with electronic health records (EHRs), allowing prescribers to view patient medication histories, check for drug interactions, and access formulary information in real time. On the pharmacy side, electronic receipt of prescriptions reduces transcription errors, accelerates processing time, and facilitates more accurate patient counseling and verification procedures. The number of e-prescribers in Florida continues to increase annually.[3]

### Federal Medicare E-Prescribing Requirements

The federal *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act* (SUPPORT Act), enacted in 2018, mandated that prescriptions for controlled substances covered under Medicare Part D be transmitted electronically beginning

[1] Medicare Part D is the voluntary federal prescription drug benefit for seniors and individuals with disabilities.
[2] If a prescriber issues 70% or more of their Part D controlled substance prescriptions electronically, they are considered in compliance with the federal Electronic Prescribing of Controlled Substances (EPCS) requirement. CMS has not yet finalized a move to raise the threshold beyond 70 percent, but the language used in Federal Register notices and CMS guidance suggests that eventual increases are likely.
[3] *Agency for Health Care Administration, 2023 Electronic Prescribing Annual Report* (Jan. 2024); *available at* https://ahca.myflorida.com/content/download/25388/file/2023eRxAnnualReport_Final.pdf (last visited Mar. 23, 2025).

January 1, 2021.[4] Federal CMS is responsible for enforcing this mandate and has established the Electronic Prescribing for Controlled Substances (EPCS) Program to oversee compliance.[5]

The Secretary of the U.S. Department of Health and Human Services *may* waive the requirements for a Medicare Part D covered schedule II, III, IV, and V controlled substance to be electronically transmitted in the case of a prescription issued:

- When the practitioner and dispensing pharmacy are the same entity;
- That cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs' Stanford Computerized Researcher Information Profile Technique (SCRIPT) Standard;
- By a practitioner who received a waiver or a renewal for a period of time, not to exceed one year, from the requirement to use electronic prescribing due to economic hardship, technological limitations outside the control of the practitioner, or other exceptional circumstances;
- By a practitioner under circumstances in which it would be impractical for the individual to obtain the substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the individual's medical condition;
- By a practitioner prescribing a drug under a research protocol;
- By a practitioner for a drug for which the Food and Drug Administration (FDA) requires a prescription to contain elements that are not able to be included in e-prescribing, such as a drug with risk evaluation and mitigation strategies that include elements to assure safe use;
- By a practitioner for an individual receiving hospice care that is not covered under the hospice Medicare benefit or a resident of a nursing facility dually eligible for Medicaid and Medicare.[6]

The Secretary has authority to revise these exceptions and generally does so annually through the Medicare physician fee schedules.[7]

Additionally, federal CMS established a 70 percent compliance threshold by rule. To be considered compliant, prescribers must electronically transmit at least 70 percent of their Schedule II through V controlled substance prescriptions under Medicare Part D during each measurement year.[8]

**Florida E-Prescribing Requirements**

Florida law generally requires prescriptions for *all* medicinal drugs, not just controlled substances, to be electronically transmitted, subject to specific exceptions. Section 456.42, F.S.,

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[4] *Substance Use–Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act,* Pub. L. No. 115-271, 132 Stat. 3894 (2018); *available at* https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf (last visited Mar. 23, 2025).

[5] *Centers for Medicare & Medicaid Services, Electronic Prescribing for Controlled Substances (EPCS) Program, available at* https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program (last visited Mar. 23, 2025).

[6] *42 U.S.C. § 1395w–104(e)(7)(B); available at* https://www.govinfo.gov/app/details/USCODE-2021-title42/USCODE-2021-title42-chap7-subchapXVIII-partD-subpart1-sec1395w-104 (last visited Mar. 23, 2025).

[7] *See* "Effect of Proposed Changes" to compare Florida's exceptions for all prescription drugs with the EPCS exceptions.

[8] *42 C.F.R. § 423.160(a)(5)(i); available at* https://www.ecfr.gov/current/title-42/section-423.160 (last visited Mar. 23, 2025).

governs written and electronic prescriptions for medicinal drugs. Under current law, a health care practitioner who is licensed to prescribe medicinal drugs and who maintains an electronic health record system or who is prescribing medicinal drugs in his or her capacity as an owner, an employee, or a contractor of a licensed health care facility or practice that maintains such a system, must electronically transmit prescriptions. This requirement also applies to practitioners prescribing on behalf of a licensed facility or practice that maintains such a system.

However, several exceptions exist in Florida law that allow prescribers to write paper prescriptions. For example, the requirement for e-prescribing does not apply if the practitioner issues fewer than 100 prescriptions annually, is located in an area under a declared state of emergency, or determines it is in the best interest of the patient to compare prescription drug prices among area pharmacies. Additional exceptions include prescribing under research protocols, for patients in hospice or nursing home care, or when a prescription cannot be electronically transmitted under the current SCRIPT standard. These exceptions are not uniformly defined in federal laws mandating the e-prescribing of controlled substances, and some have been eliminated at the federal level.

Section 456.43, F.S., authorizes the Department of Health (DOH) to issue waivers from the electronic prescribing requirement for up to one year, based on demonstrated economic hardship, technological limitations, or other exceptional circumstances. It also authorizes the DOH to adopt rules and coordinate with professional boards to implement and enforce the e-prescribing requirements. Electronic prescribing may not interfere with a patient's freedom to choose a pharmacy.[9]

## III. Effect of Proposed Changes:

**Section 1** amends s. 456.42, F.S., to require health care practitioners who are licensed by law to prescribe a medicinal drug and who are prescribing medicinal drugs in their capacity as an owner, an employee, or a contractor of a licensed health care facility or practice that maintains a system of electronic health records[10] to electronically transmit prescriptions for such drugs. The bill creates, retains in current law, and removes exceptions to this requirement, as follows.

The bill creates the following three exceptions:

- *(a) The practitioner prescribes fewer than 100 such prescriptions annually;*
  This is intended to mirror the "Small Prescriber Exception" from Electronic Prescribing for Controlled Substances (EPCS) requirements which federal Centers for Medicare and Medicaid Services (CMS) automatically provides to prescribers who issue 100 or fewer qualifying Medicare Part D controlled substance prescriptions in the measurement year.[11]

- *(b) The practitioner is located in an area for which a state of emergency is declared pursuant to s. 252.36, F.S.;*

[9] Section 456.43, F.S.
[10] "Electronic health record" means a record of a person's medical treatment which is created by a licensed health care provider and stored in an interoperable and accessible digital format. Section 408.051, F.S.
[11] *Centers for Medicare & Medicaid Services, Electronic Prescribing for Controlled Substances (EPCS) Program, available at* https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program (last visited Mar. 23, 2025).

This is intended to mirror the "Declared Disaster Exception" from EPCS requirements which CMS automatically provides to prescribers located in the geographic area of an emergency or disaster declared by a federal, state, or local government entity.[12]

- *(e) The prescription is not able to be electronically prescribed due to a temporary technological or electrical failure that is not in the control of the prescribing practitioner and such failure is documented in the patient record;*
  This exception would be unique to Florida law and does not mirror any federal exception from EPCS requirements.

The bill retains the following four exceptions in current law:

- *(c) The practitioner has been issued a waiver by the department, not to exceed one year in duration, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or another exceptional circumstance demonstrated by the practitioner;*
  This is similar to the "CMS-Approved Waiver" exception. Federal CMS provides this exception to prescribers who submit and receive a federal CMS-approved waiver because the prescriber is unable to meet the federal CMS EPCS Program requirement due to circumstances beyond the prescriber's control.[13]

- *(d) The practitioner reasonably determines that it would be impractical for the patient in question to obtain a medicinal drug prescribed by electronic prescription in a timely manner and such delay would adversely impact the patient's medical condition;*
  This was intended to mirror a similar federal requirement which has since been removed. On November 18, 2022, federal CMS published the 2023 Physician Fee Schedule final rule (CMS 1770 F)[14], which removed the exception to the EPCS requirement for prescriptions issued when it would be impractical for the patient to obtain the prescribed substance electronically and a delay would adversely impact the patient's medical condition.

- *(f) The prescription is issued to an individual receiving hospice care. The bill removes the exception for residents of nursing home facilities.*
  The bill retains part of this exception, for individuals receiving hospice care and deletes the exception for residents of nursing home facilities. The exemption for individuals receiving hospice care from the federal electronic prescribing requirements for controlled substances under Medicare Part D was removed with the publication of the 2024 Physician Fee Schedule final rule (CMS-1784-F) by federal CMS on November 16, 2023.[15]

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[12] *Id.*
[13] *Centers for Medicare & Medicaid Services, Electronic Prescribing for Controlled Substances (EPCS) Program, available at* https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program (last visited Mar. 23, 2025).
[14] Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule, 87 Fed. Reg. 69404 (Nov. 18, 2022); available at https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf. (last visited Mar. 23, 2025).
[15] *Centers for Medicare & Medicaid Services, Medicare Program: CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Final Rule,* 88 Fed. Reg. 81280, 82539 (Nov. 16, 2023) (to be codified at 42 C.F.R. pt. 423).

- *(g) The practitioner determines that it is in the best interest of the patient, or the patient determines that it is in his or her own best interest, to compare prescription drug prices among area pharmacies. The practitioner must document such determination in the patient's medical record.*
  This exception is unique to Florida law and is consistent with s. 456.24, F.S., which establishes that electronic prescribing may not interfere with a patient's freedom to choose a pharmacy.

The bill deletes four exceptions listed in current law, and one in part, including all of the following:

- *(a) The practitioner and the dispenser are the same entity;*
  This was intended to mirror a similar federal requirement which has since been removed. On November 16, 2023, federal CMS published the 2024 Physician Fee Schedule final rule (CMS-1784-F)[16] which removed the exception to the EPCS requirement for prescriptions where the prescriber and dispensing pharmacy are the same legal entity. Effective January 1, 2025, all prescriptions for controlled substances under Medicare Part D must be transmitted electronically, regardless of whether the prescriber and dispenser are part of the same legal entity.

- (*b) The prescription cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;*
  This was intended to mirror federal authority given to the Secretary of U.S. Department of Health and Human Services that was never exercised. The 2021 Physician Fee Schedule final rule (CMS-1734-F),[17] published on December 28, 2020, mandated that prescribers use the NCPDP National Council for Prescription Drug Programs' Stanford Computerized Researcher Information Profile Technique (SCRIPT) Standard Version 2017071 for EPCS transmissions. By adopting this standard, federal CMS did not include exceptions for prescriptions that could not be transmitted electronically under the most recent SCRIPT standard, thereby eliminating any previous allowances for such limitations.

- *(e) The practitioner is prescribing a drug under a research protocol;*
  This was intended to mirror a similar federal requirement which has since been removed. The exception permitting practitioners to issue non-electronic prescriptions for controlled substances when prescribing under a research protocol was removed in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule final rule (CMS-1751-F),[18] which was published on November 19, 2021. In this rule, federal CMS finalized specific exceptions to

[16] *Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Final Rule*, 88 Fed. Reg. 81280 (Nov. 16, 2023), *available at* https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other (last visited Mar. 23, 2025).
[17] *Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule*, 85 Fed. Reg. 84472 (Dec. 28, 2020); *available at* https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf. (last visited Mar. 23, 2025).
[18] *Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule*, 86 Fed. Reg. 64996 (Nov. 19, 2021); *available at* https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf. (last visited Mar. 23, 2025).

the EPCS requirement, and the exception for prescriptions under a research protocol was not included among them, effectively removing it.

- *(f) The prescription is for a drug for which the federal Food and Drug Administration requires the prescription to contain elements that may not be included in electronic prescribing;*
  This was intended to mirror a similar federal requirement which has since been removed. The exception allowing practitioners to issue non-electronic prescriptions for drugs requiring specific elements by the Food and Drug Administration (FDA) that could not be included in electronic prescriptions was also removed in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule final rule (CMS-1751-F).[19] In this rule, CMS finalized specific exceptions to the Electronic Prescribing for Controlled Substances (EPCS) requirement, and the exception for prescriptions requiring FDA-mandated elements not supported by electronic prescribing was not included among them, effectively removing it.

- *(g) The prescription is issued to an individual… who is a resident of a nursing home facility;*
  The bill deletes part of this exception, for residents of nursing home facilities and retains the exception for individuals receiving hospice care. The exception for residents of long-term care (LTC) facilities (which generally include nursing home facilities in Florida law) from the federal electronic prescribing requirements for controlled substances under Medicare Part D has been extended by three years, from 2025 to 2028.[20] The CMS finalized a policy to delay compliance actions against prescribers who do not meet the EPCS requirement for prescriptions written for beneficiaries in LTC facilities until January 1, 2028.[21] This extension aligns the timeline for EPCS compliance in LTC facilities with the adoption of updated electronic prescribing standards that include improved communication functionalities between pharmacies and LTC facilities.[22]

Prescribers who no longer qualify for an exception would be required to establish compliance with the bill's e-prescribing requirement upon their next scheduled license renewal or by July 1, 2026, whichever occurs first.

The Department of Health (DOH), in consultation with the Board of Medicine, the Board of Osteopathic Medicine, the Board of Podiatric Medicine, the Board of Dentistry, the Board of Nursing, and the Board of Optometry, is authorized, but not required to, adopt rules to implement this subsection encompassing the e-prescribing requirement. With this rulemaking authority, the DOH has incorporated a Request for Waiver form by reference, which would need to be updated to conform with changes made by the bill in its introductory paragraph.[23]

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[19] *Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule,* 86 Fed. Reg. 64996 (Nov. 19, 2021); *available at* https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf. (last visited Mar. 23, 2025).
[20] *American Medical Association, Summary of Final CY 2025 Medicare Physician Fee Schedule (PFS) Rule,* at 8 (2023); available at https://www.ama-assn.org/system/files/ama-2025-mpfs-summary.pdf (last visited Mar. 23, 2025).
[21] *Centers for Medicare & Medicaid Services, Electronic Prescribing for Controlled Substances (EPCS) Program,* available at https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program (last visited Mar. 23, 2025).
[22] *American Medical Association, Summary of Final CY 2025 Medicare Physician Fee Schedule (PFS) Rule,* at 8 (2023); available at https://www.ama-assn.org/system/files/ama-2025-mpfs-summary.pdf (last visited Mar. 23, 2025).
[23] Rule 64B-3.009, F.A.C. (2025).

The bill also clarifies that Florida's e-prescribing requirement does not prohibit a pharmacist licensed in this state from filling or refilling a valid prescription submitted electronically or in writing, or require or authorize a change in prescription drug claims adjudication and review procedures by payors related to filling or refilling a valid prescription submitted electronically or in writing; nor does it prohibit a pharmacist licensed in this state from filling or refilling a valid prescription that is issued in writing by a prescriber located in another state or that is transcribed by the pharmacy when a prescription is called in by telephone.

**Section 2** republishes s. 456.43, F.S., to reaffirm that the use of e-prescribing may not interfere with a patient's freedom to choose a pharmacy.

**Sections 3 and 4** amend ss. 458.347 and 459.022, F.S., respectively, to conform a cross-reference to subsection (1) of s. 456.42, F.S., which is redesignated as subsection (2) in section 1 of the bill.

The bill takes effect 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 bill would require both the Department of Health (DOH) and the Board of Pharmacy to update rules that reference subsections of statute that are renumbered by the bill. [24] Additionally, all prescribing practitioners would need to be notified of the new requirements through the customer contact center virtual agent (ELI), board websites, and email notifications. The DOH indicates that current resources and budget authority are sufficient to absorb these nonrecurring costs and the temporary increase in workload. [25]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.42, 458.347, and 459.022.

The bill republishes section 456.43 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.)

**CS by Appropriations Committee on Health and Human Services on April 10, 2025:**
The committee substitute (CS) restores several exceptions to Florida's electronic prescribing requirement that are provided in current law but were removed by the underlying bill. Specifically, the CS retains exceptions for:

- When the practitioner reasonably determines that it would be impractical for the patient in question to obtain a medicinal drug prescribed by electronic prescription in a timely manner and such delay would adversely impact the patient's medical condition;
- Prescriptions issued to individuals receiving hospice care. Under current law this exception is extended to individuals in nursing home facilities. The CS excludes residents of nursing home facilities from this exception; and
- For circumstances in which it is in the best interest of the patient to compare prescription drug prices among area pharmacies.

[24] Rules 64B-3.009 and 64B16-27.831(5), F.A.C. (2025).
[25] Department of Health, Senate Bill 1568, Legislative Analysis (Mar. 11, 2025) (on file with the Senate Committee on Health Policy).

The CS creates a new exception for prescriptions that cannot be electronically prescribed due to temporary technological or electrical failure that are out of the control of the prescribing practitioner.

The CS also clarifies that the electronic prescribing requirement does not prohibit a pharmacist from filling or refilling valid prescriptions.

The CS republishes a provision to reaffirm that the use of electronic prescribing may not interfere with a patient's freedom to choose a pharmacy.

B. Amendments:

None.

584482

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RS | . | |
| 04/10/2025 | . | |
| | . | |
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The Appropriations Committee on Health and Human Services (Brodeur) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 31 - 64

and insert:

state of emergency is declared pursuant to s. 252.36;

~~(a) The practitioner and the dispenser are the same entity;~~

~~(b) The prescription cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;~~

(c) The practitioner has been issued a waiver by the

584482

department, not to exceed 1 year in duration, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or another exceptional circumstance demonstrated by the practitioner;

(d) ~~The practitioner reasonably determines that it would be impractical for the patient in question to obtain a medicinal drug prescribed by electronic prescription in a timely manner and such delay would adversely impact the patient's medical condition;~~

~~(e) The practitioner is prescribing a drug under a research protocol;~~

~~(f) The prescription is for a drug for which the federal Food and Drug Administration requires the prescription to contain elements that may not be included in electronic prescribing;~~

~~(g)~~ The prescription is issued to an individual receiving hospice care ~~or who is a resident of a nursing home facility~~; or

(e) ~~(h)~~ The practitioner determines that it is in the best interest of the patient, or the patient determines that it is in his or her own best interest, to compare prescription drug prices among area pharmacies. The practitioner must document such determination in the patient's medical record.

The department, in consultation with the Board of Medicine, the Board of Osteopathic Medicine, the Board of Podiatric Medicine, the Board of Dentistry, the Board of Nursing, and the Board of Optometry, may adopt rules to implement this subsection.

Section 2. Subsection (1) of section 456.43, Florida

584482

Statutes, is republished to read:

456.43 Electronic prescribing for medicinal drugs.—

(1) Electronic prescribing may not interfere with a patient’s freedom to choose a pharmacy.

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

And the title is amended as follows:

Delete line 5

and insert:

certain drugs; revising exceptions; republishing s. 456.43(1), F.S., relating to electronic prescribing for medicinal drugs; amending ss.

909488

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/10/2025 | . | |
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| | . | |

The Appropriations Committee on Health and Human Services (Brodeur) recommended the following:

**Senate Substitute for Amendment (584482) (with title amendment)**

Delete lines 31 - 64

and insert:

state of emergency is declared pursuant to s. 252.36;

~~(a) The practitioner and the dispenser are the same entity;~~

~~(b) The prescription cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;~~

909488

(c) The practitioner has been issued a waiver by the department, not to exceed 1 year in duration, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or another exceptional circumstance demonstrated by the practitioner;

(d) The practitioner reasonably determines that it would be impractical for the patient in question to obtain a medicinal drug prescribed by electronic prescription in a timely manner and such delay would adversely impact the patient's medical condition;

(e) The prescription cannot be electronically prescribed due to a temporary technological or electrical failure that is not in the control of the prescribing practitioner, and such failure is documented in the patient record ~~The practitioner is prescribing a drug under a research protocol~~;

(f) ~~The prescription is for a drug for which the federal Food and Drug Administration requires the prescription to contain elements that may not be included in electronic prescribing;~~

~~(g)~~ The prescription is issued to an individual receiving hospice care ~~or who is a resident of a nursing home facility~~; or

(g)~~(h)~~ The practitioner determines that it is in the best interest of the patient, or the patient determines that it is in his or her own best interest, to compare prescription drug prices among area pharmacies. The practitioner must document such determination in the patient's medical record.

The department, in consultation with the Board of Medicine, the

909488

Board of Osteopathic Medicine, the Board of Podiatric Medicine, the Board of Dentistry, the Board of Nursing, and the Board of Optometry, may adopt rules to implement this subsection. This subsection does not prohibit a pharmacist licensed in this state from filling or refilling a valid prescription submitted electronically or in writing, or require or authorize a change in prescription drug claims adjudication and review procedures by payors related to filling or refilling a valid prescription submitted electronically or in writing. This subsection does not prohibit a pharmacist licensed in this state from filling or refilling a valid prescription that is issued in writing by a prescriber located in another state or that is transcribed by the pharmacy when a prescription is called in by telephone.

Section 2. Subsection (1) of section 456.43, Florida Statutes, is republished to read:

456.43 Electronic prescribing for medicinal drugs.—

(1) Electronic prescribing may not interfere with a patient’s freedom to choose a pharmacy.

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

And the title is amended as follows:

Delete line 5

and insert:

certain drugs; revising exceptions; providing construction; republishing s. 456.43(1), F.S., relating to electronic prescribing for medicinal drugs; amending ss.

**By** Senator Brodeur

10-01056A-25 20251568__

A bill to be entitled

An act relating to electronic prescribing; amending s. 456.42, F.S.; revising health care practitioners who may only electronically transmit prescriptions for certain drugs; revising exceptions; amending ss. 458.347 and 459.022, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (1) and (2) of section 456.42, Florida Statutes, are redesignated as subsections (2) and (3), respectively, and present subsection (3) of that section is redesignated as subsection (1) and amended, to read:

456.42 ~~Written~~ Prescriptions for medicinal drugs.—

(1)~~(3)~~ A health care practitioner licensed by law to prescribe a medicinal drug who ~~maintains a system of electronic health records as defined in s. 408.051(2)(c), or who~~ prescribes medicinal drugs as an owner, an employee, or a contractor of a licensed health care facility or practice that maintains ~~such~~ a system of electronic health records as defined in s. 408.051(2)(c) and who is prescribing in his or her capacity as such an owner, an employee, or a contractor~~,~~ may only electronically transmit prescriptions for such drugs. This requirement applies to such a health care practitioner upon renewal of the health care practitioner's license or by July 1, 2026 ~~2021~~, whichever is earlier, but does not apply if:

(a) The practitioner prescribes fewer than 100 such prescriptions annually;







10-01056A-25 20251568__

(b) The practitioner is located in an area for which a state of emergency is declared pursuant to s. 252.36; or

~~(a) The practitioner and the dispenser are the same entity;~~

~~(b) The prescription cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;~~

(c) The practitioner has been issued a waiver by the department, not to exceed 1 year in duration, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or another exceptional circumstance demonstrated by the practitioner~~;~~

~~(d) The practitioner reasonably determines that it would be impractical for the patient in question to obtain a medicinal drug prescribed by electronic prescription in a timely manner and such delay would adversely impact the patient's medical condition;~~

~~(c) The practitioner is prescribing a drug under a research protocol;~~

~~(f) The prescription is for a drug for which the federal Food and Drug Administration requires the prescription to contain elements that may not be included in electronic prescribing;~~

~~(g) The prescription is issued to an individual receiving hospice care or who is a resident of a nursing home facility; or~~

~~(h) The practitioner determines that it is in the best interest of the patient, or the patient determines that it is in his or her own best interest, to compare prescription drug prices among area pharmacies. The practitioner must document~~

~~such determination in the patient's medical record~~.

The department, in consultation with the Board of Medicine, the Board of Osteopathic Medicine, the Board of Podiatric Medicine, the Board of Dentistry, the Board of Nursing, and the Board of Optometry, may adopt rules to implement this subsection.

Section 2. Paragraph (e) of subsection (4) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed on the formulary created pursuant to paragraph (f). A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that he or she is a physician assistant.

2. The supervising physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to paragraph (f).





4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit, designated by the American Academy of Physician Assistants as a Category 1 credit, or designated by the American Osteopathic Association as a Category 1-A credit.

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(2) ~~456.42(1)~~ and chapter 499 and must contain the physician assistant's name, address, and telephone number and the name of each of his or her supervising physicians. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465 and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465.

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

Section 3. Paragraph (e) of subsection (4) of section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or

dispense any medication used in the supervising physician's practice unless such medication is listed on the formulary created pursuant to s. 458.347. A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that she or he is a physician assistant.

2. The supervising physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to s. 458.347(4)(f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a provider that has been approved by the American Academy of Physician Assistants and which is designated for the American Medical Association Physician's Recognition Award Category 1 credit, designated by the American Academy of Physician Assistants as a Category 1 credit, or designated by the American Osteopathic Association as a Category 1-A credit.





5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(2) ~~456.42(1)~~ and chapter 499 and must contain the physician assistant's name, address, and telephone number and the name of each of his or her supervising physicians. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465, and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465.

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

Section 4. This act shall take effect July 1, 2025.

The Florida Senate

# Committee Agenda Request

**To:** Senator Jay Trumbull, Chair
Appropriations Committee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** March 31, 2025

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I respectfully request that **Senate Bill #1568**, relating to Electronic Prescribing, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Jason Brodeur

Senator Jason Brodeur
Florida Senate, District 10

File signed original with committee office

S-020 (03/2004)

The Florida Senate

# APPEARANCE RECORD

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

4,10 - 2025
Meeting Date

Approps on HHS
Committee

SB 1568
Bill Number or Topic

909488
Amendment Barcode (if applicable)

Name Paul Ledford

Phone 850. 321. 4617

Address 817 N. Gadsden St
Street

Email paul@floridahospices.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:
Florida Hospice + Palliative Care Assn

☐ 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1606 |
| INTRODUCER: | Health Policy Committee and Senator Grall |
| SUBJECT: | Patient Access to Records |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Smith | Brown | HP | **Fav/CS** |
| 2. | Gerbrandt | McKnight | AHS | **Favorable** |
| 3. | | | RC | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 1606 standardizes the timeframe for responding to patient records requests for patients, residents, and their legal representatives. Under current 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.

The bill requires 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.

Current law 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 has no fiscal impact on state expenditures or revenues**. See Section V., Fiscal Impact Statement.**

The bill takes effect 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 HIPPA 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 HIPPA 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

[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.

maintained by or for a covered entity that is used, in whole or in part, to make decisions about individuals. These records include:

- 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

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[7] 45 C.F.R. § 164.501.
[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).

safeguards, so long as they do not authorize disclosures or impose barriers that conflict with HIPAA's requirements.

**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 information technology), 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

[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.

requests, maintaining health information technology performance, complying with licensing restrictions, and limiting the manner of access.[24]

Enforcement of the Information Blocking Rule is governed by 42 U.S.C. § 300jj-52(b). The 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.

[24] 45 C.F.R. §§ 171.200–171.303.
[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** 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** 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.

The bill changes the term "agency" (as in the Agency for Health Care Administration) to "Department of Health" (DOH) 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** 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** 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** 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] including

[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

facilities, that are licensed, registered, or certified by the Agency for Healthcare Administration (AHCA) and not otherwise addressed in statute. Records maintained by psychiatric hospitals, substance abuse treatment providers, or nursing homes are exempt from this section under the bill.

The bill 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.

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.

**Section 6** amends s. 456.057, F.S., to require **any health care practitioner**[38] licensed by the DOH who is not exempt[39] to furnish copies of requested records 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 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** 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** provides that the bill will take effect January 1, 2026.

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[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] Section 456.057(2), F.S., exempts the following persons: certified nursing assistants, pharmacists and pharmacies, dental hygienists, nursing home administrators, respiratory therapists, athletic trainers, electrologists, clinical laboratory personnel, medical physicists, opticians and optical establishments, and persons or entities practicing under s. 627.736(7), F.S.

## 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:

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:

The bill has no impact on state expenditures or revenues.

## 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.

**By** the Committee on Health Policy; and Senator Grall

588-03143-25 20251606c1

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







588-03143-25 20251606c1

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, 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

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 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 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 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 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, 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 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 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 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.

The Florida Senate

# Committee Agenda Request

**To:** Senator Jay Trumbull, Chair
Appropriations Committee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** April 2, 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)

The Florida Senate

# APPEARANCE RECORD

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

4/10/25
Meeting Date

HHS Aprops
Committee

1606
Bill Number or Topic

Amendment Barcode (if applicable)

Name Elizabeth McElhiney

Phone EMcelhiney@verisma.com

Address 300 W. Pensacola
Street

Email 863 608 6658

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:

*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

10 Apr 25
Meeting Date

Approp HHS
Committee

1606
Bill Number or Topic

Amendment Barcode (if applicable)

Name Cynthia Henderson

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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: AH105

☐ 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

10 Apr 25
Meeting Date

Approp HHS
Committee

1606
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dr. David Bellamy

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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:

☐ 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1620 |
| INTRODUCER: | Children, Families, and Elder Affairs Committee and Senator Rouson |
| SUBJECT: | Mental Health and Substance Use Disorders |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Kennedy | Tuszynski | CF | **Fav/CS** |
| 2. | Sneed | McKnight | AHS | **Favorable** |
| 3. | | | FP | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 1620 codifies recommendations made by Florida's Commission on Mental Health and Substance Use Disorder by making the following changes to Florida's Mental Health Act:

- Defines person-first language to mean language used in a professional medical setting which emphasizes the patient as a person rather than his or her disability or illness and requires use and promotion of person-first language as the standard in professional behavioral health settings.
- Ensures access to mobile response services for persons 65 years of age or older.
- Requires the continued promotion of best practices in crisis intervention and trauma-informed care.
- Requires that individualized treatment plans for adults and juveniles be reevaluated at least every six months.
- Requires the use and statewide integration of the Daily Living Activites-20 function assessment tool.
- Requires the Department of Children and Families (DCF) to review discharge procedures and evaluate access to prescribed behavioral health medications, including data on adherence and readmissions. In collaboration with the Agency for Health Care Administration (AHCA), the DCF must report findings and recommend policies with cost estimates to improve access and promote the use of long-acting injectables as a discharge medication.
- Requires the DCF to conduct reviews every other year and the AHCA to prioritize licensing for short-term residential treatment facilities in underserved counties and high-need areas.

The bill also requires the DCF and the Department of Education to conduct reviews every other year to identify effective models of school-based behavioral health access, particularly in underserved and rural areas, and submit their findings to the Governor and Legislature.

The bill establishes the Center for Substance Abuse and Mental Health Research at the University of South Florida's Louis de la Parte Florida Mental Health Institute to conduct statewide behavioral health research, promote evidence-based practices, and improve workforce development.

The bill has a significant negative fiscal impact on state revenues and expenditures. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

The present situation is presented in Section III under the Effect of Proposed Changes.

## III. Effect of Proposed Changes:

### Background

#### *Florida Mental Health Act*

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[1] The Baker Act details Florida's mental health commitment laws and includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations.[2] The Baker Act also protects the rights of all individuals examined or treated for mental illness in Florida.[3]

The Department of Children and Families (DCF) is responsible for the operation and administration of the Baker Act as part of a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g., crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services.

#### *Florida's Commission on Mental Health and Substance Abuse*

In 2021, the Legislature created the Commission on Mental Health and Substance Abuse (Commission) in response to recommendations of the 20th Statewide Grand Jury.[4] The DCF is

[1] Ch. 71-131, LO.F.; The Baker Act is contained in ch. 394, F.S.
[2] Sections 394.451-394.47891, F.S.
[3] Section 394.459, F.S.
[4] Chapter 2021-170, L.O.F.; *See* Supreme Court of Florida, *Second Interim Report of the Twentieth Statewide Grand Jury*, Case No. SC19-240, available at: https://www.myfloridalegal.com/files/pdf/page/E848FB422443B604852584CE000A6AB0/20SGJ+Second+Interim+Report.pdf (last visited 3/20/25).

required to provide administrative staff and support services for the Commission.[5] The purposes of the Commission include:

- Examining the current methods of providing mental health and substance abuse services in the state;
- Improving the effectiveness of current practices, procedures, programs, and initiatives in providing such services;
- Identifying any barriers or deficiencies in the delivery of such services; and
- Recommending changes to existing laws, rules, and policies necessary to implement the Commission's recommendations.[6]

The duties of the Commission include:

- Review and evaluate the management and functioning of existing publicly supported mental health and substance abuse systems in the DCF, AHCA, and all other relevant state departments;
- Consider the unique needs of people who are dually diagnosed;
- Address access to, financing of, and scope of responsibility in the delivery of emergency behavioral health care services;
- Address the quality and effectiveness of current service delivery systems and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers;
- Address priority population groups for publicly funded services, identify the comprehensive delivery systems, needs assessment and planning activities, and local government responsibilities for funding services;
- Identify gaps in the provision of mental health and substance abuse services;
- Provide recommendations on how managing entities may promote service continuity;
- Make recommendations about the mission and objectives of state-supported mental health and substance abuse services and the planning, management, staffing, financing, contracting, coordination, and accountability of mechanisms best suited for the recommended mission and objectives; and
- Evaluate and make recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, behavioral health, substance abuse, and related services statewide.[7]

The Commission was required to submit an initial report by January 1, 2023, and annually thereafter. A final report is due by September 1, 2026, to the Governor, President of the Senate, and Speaker of the House of Representatives on the Commission's findings and recommendations on how to best provide and facilitate mental health and substance abuse services.[8]

[5] Section 394.9086(1), F.S.
[6] Section 394.9086(2), F.S.
[7] Section 394.9086(4)(a), F.S.
[8] Section 394.9086(5), F.S.

The Commission's 2025 Annual Interim Report has 30 recommendations that address a wide range of topics, to include the planning, management, staffing, and coordination of state-supported mental health and substance use disorder services.[9]

**Person-First Language in Medical Care**

***Present Situation***

Person-first language (PFL) is a communication approach that emphasizes the individual before their condition, promoting respect and reducing stigma. This approach is widely adopted in the United States across various sectors, including healthcare, education, and government agencies. According to PFL, when referring to a person with a disability, refer to the person first, by using phrases such as, "a person who ...", "a person with ...", or "a person who has ..."[10] The Centers for Disease Control and Prevention (CDC) advocates for PFL to foster dignity and respect when discussing disabilities.[11] Similarly, the National Institutes of Health (NIH) recommends using PFL to avoid defining individuals by their disabilities, suggesting terms like "person with cancer" instead of "cancer patient."[12] The evolution of disability language reflects a growing emphasis on self-identification, autonomy, and respect for diverse perspectives within the disability community.

The Commission recommends the regular sharing of best practices, the use of de-stigmatizing person-first language, and trauma-responsive care to improve patient experience and engagement in treatment.[13]

***Effect of Proposed Changes***

**Section 1** amends s. 394.455, F.S., to establish a statutory definition for "person-first language" to mean language used in a professional medical setting which emphasizes the patient as a person rather than his or her disability or illness.

**Section 2** amends s. 394.457, F.S., to require the DCF to adopt rules to ensure access to mobile response services for persons 65 years of age or older and require the sharing of best practices with medical professionals, to include person-first language and trauma-responsive care, as part of the minimum standards of a mobile crisis response service.

**Section 6** amends s. 394.659, F.S., to require the Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center to disseminate best practices for crisis intervention, person-

[9] Commission on Mental Health and Substance Use Disorder, *Annual Interim Report*, January 1, 2025, p. 23, available at: https://www.myflfamilies.com/sites/default/files/2024-12/2025%20Commission%20on%20Mental%20Health%20and%20Substance%20Use%20Disorder%20Interim%20Report.pdf (last visited 3/20/25).
[10] U.S. Centers for Disease Control and Prevention, *Communicating with and About People with Disabilities*, available at https://www.cdc.gov/disability-and-health/articles-documents/communicating-with-and-about-people-with-disabilities.html (last visited 3/20/2025).
[11] *Id.*
[12] National Institutes of Health, *Person-first and Destigmatizing Language*, available at https://www.nih.gov/nih-style-guide/person-first-destigmatizing-language (last visited 3/20/2025).
[13] *Supra*, Note 9, p. 43.

first language, and trauma-informed care among grantees to improve patient experience and outcomes and encourage cooperative engagement.

**Assessments and the Daily Living Activities-20 Functional Assessment Tool**

***Present Situation***

The Daily Living Activities-20 (DLA-20) is a functional assessment tool designed to evaluate daily living areas affected by mental illness or disability.[14] It measures 20 domains of daily activities, providing a 30-day snapshot of an individual's strengths and needs related to whole health.[15] The DLA-20 is suitable for individuals aged 6 and up, regardless of diagnosis, disability, or cultural background.[16] Used in 43 states, including 14 statewide, it serves over a million clients through 500 providers and 35,000 clinicians.[17] The DLA-20 is a dependable and effective tool for evaluating an individual's ability to perform daily living activities, offering healthcare providers meaningful insights to tailor treatment plans. By streamlining the assessment process, it helps measure quality of life, monitor progress, and support improved care for individuals receiving behavioral health services.[18]

The Commission recommends the increase in the number of functional assessments performed and the encouragement of statewide implementation of the DLA-20 functional assessment tool.[19]

***Effect of Proposed Changes***

**Section 3** amends s. 394.459(2), F.S., to enhance the rights of patients and require that individualized treatment plans be reevaluated at least every six months to ensure that the recommended care remains necessary and appropriate.

**Section 5** amends s. 394.495, F.S., to require the DCF to reevaluate child and adolescent mental health assessment services every six months to ensure patients' clinical needs are met. The section also requires evaluation and screening of a child or adolescent's functional daily living through implementation of the Daily Living Activities-20 (DLA-20) functional assessment tool.

**Section 8** amends s. 394.9086, F.S., to require the Commission to identify and assess mental health and substance use disorder needs and planning activities, to include the use of the Daily Living Activities-20 (DLA-20) functional assessment tool.

**Section 10** amends s. 1006.041, F.S., to require that the DLA-20 functional assessment tool be implemented in school-based mental health programs. Additionally, the DCF and the

[14] MTM Consulting Service, *DLA-20 Outcomes Measurement and Monitoring*, available at https://www.mtmservices.org/dla (last visited March 20, 2025).
[15] MTM Services, *DLA-20 Fact Sheet*, available at https://static1.squarespace.com/static/59c005cd8a02c7dae8cd5e80/t/5e680c77273bb43fae3ac99c/1583877239917/DLA20+Factsheet+-+Updated+March+2020.pdf (last visited March 20, 2025).
[16] MTM Consulting Service, *DLA-20 Outcomes Measurement and Monitoring*, available at https://www.mtmservices.org/dla (last visited March 20, 2025).
[17] *Id.*
[18] National Council for Mental Wellbeing, *DLA-20 Functional Assessment Guide*, available at https://www.thenationalcouncil.org/product/dla-20-functional-assessment-guide/ (last visited March 20, 2025).
[19] *Supra*, Note 9, pp. 26-27.

Department of Education must conduct biennial reviews of effective school-based behavioral health access models, particularly in underserved and rural areas, and submit their findings to the Governor and Legislature.

**The Louis de la Parte Florida Mental Health Institute**

***Present Situation***

Section 1004.44, F.S., establishes the Louis de la Parte Florida Mental Health Institute (FMHI) within the University of South Florida. The purpose of the FMHI is to strengthen mental health services throughout the state by providing technical assistance and support to mental health agencies and professionals. Such assistance and services include:

- Technical training and specialized education.
- Development, implementation, and evaluation of mental health services programs.
- Evaluation of availability and effectiveness of existing mental health services.
- Analysis of factors that influence the incidence and prevalence of mental and emotional disorders.
- Dissemination of information about innovations in mental health services.
- Consultation on all aspects of program development and implementation.
- Provisions for direct client services, provided for a limited period of time either in the institute facility or in other facilities within the state, and limited to purposes of research or training.

Florida Center for Behavioral Health Workforce

The FCBHW was established within the Louis de la Parte FMHI at the University of South Florida (USF) to address the critical shortage of mental health professionals in the state.[20] The FCBHW's mission encompasses conducting original research, performing policy analysis, and developing best practices to support a skilled and resilient behavioral health workforce. By identifying workforce gaps and enhancing educational pathways, the center aims to ensure that Floridians have access to high-quality behavioral health services. [21]

The Commission recommends the bolstering of the behavioral health sector through workforce development and retention efforts.[22]

***Effect of Proposed Changes***

**Section 9** amends s. 1004.44, F.S., to require the FCBHW at the Louis de la Parte Florida Mental Health Institute to conduct a biennial workforce supply and demand analysis and develop recruitment and retention strategies for behavioral health professionals. New workforce developments include:

- Conducting a biennial workforce supply and demand analysis to assess behavioral health staffing shortages.
- Expanding pathways for mental health professionals, such as:

[20] Section 1004.44(6)(a).
[21] *Id.*
[22] *Supra*, Note 9, p. 37.

  - Enhancing educational opportunities and faculty development.
  - Supporting clinical training programs for new professionals.
  - Exploring loan forgiveness or incentive programs to retain behavioral health workers.
- Promoting behavioral health professions through research on recruitment and retention trends.
- Collecting and analyzing compensation and benefits data to assess workforce sustainability.
- Implementing a statewide behavioral health workforce survey at the time of professional licensure and renewal to track provider trends and needs.

The bill establishes the Center for Substance Abuse and Mental Health Research (Center), which will conduct research on evidence-based treatments, workforce shortages, and best practices to improve behavioral health care statewide. The Center will:

- Conduct scientific research on substance abuse and mental health disorders.
- Study the link between substance use and mental illness, including co-occurring disorders.
- Develop and evaluate evidence-based prevention and treatment strategies.
- Investigate alternative, low-cost interventions, particularly for underserved and rural communities.
- Utilize technology-based treatment models, such as telehealth and digital interventions.
- Collaborate with community organizations and providers to promote research-driven improvements in behavioral health care.

**Long-acting Injectables**

***Present Situation***

Long-acting injectables (LAIs) are injectable medications used for individuals living with mental illness. They are typically the same medications as their oral counterparts but formulated to release slowly into the bloodstream over an extended period.[23] This extended release allows for less frequent dosing, ranging from every two weeks to every six months, depending on the specific medication.[24] LAIs are primarily used to treat psychosis, including hallucinations or delusions, in individuals with schizophrenia. Some LAIs may also serve as mood stabilizers for those with bipolar disorder.[25] By providing a steady level of medication in the blood, LAIs help individuals adhere to their medication plans, potentially reducing hospitalization and improving relationships with family and friends.

The Commission recommends the increased use of long-acting injectables prior to discharge from state mental health treatment facilities and community mental health providers, leading to better symptom control.[26]

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[23] National Alliance on Mental Illness, *What You Need to Know About Long-Acting Injectables (LAIs)*, available at https://www.nami.org/NAMI/media/NAMI-Media/Research/Long-Acting-Injectables_2022.pdf (last visited March 20, 2025).
[24] National Alliance on Mental Illness, *Long-Acting Injectables (LAIs)*, available at https://www.nami.org/about-mental-illness/treatments/mental-health-medications/long-acting-injectables-lais/ (last visited March 20, 2025).
[25] *Id*.
[26] Commission on Mental Health and Substance Use Disorder, *Annual Interim Report*, January 1, 2025, p. 23, available at: https://www.myflfamilies.com/sites/default/files/2024-12/2025%20Commission%20on%20Mental%20Health%20and%20Substance%20Use%20Disorder%20Interim%20Report.pdf (last visited 3/20/25).

### *Effect of Proposed Changes*

**Section 4** amends s. 394.468, F.S., to require the DCF, in collaboration with the AHCA, to review discharge procedures at receiving facilities and evaluate access to prescribed behavioral health medications. The review must include data on medication adherence and readmission rates. A report with findings, policy recommendations, and cost estimates must be submitted to the Governor, Senate President, and Speaker of the House by December 31, 2025.

## Short-term Residential Treatment

### *Present Situation*

Short-term residential treatment (SRT) programs in Florida were established to provide structured, live-in, non-hospital settings with 24-hour supervision for individuals experiencing mental health crises.[27] These programs serve as a bridge between acute care settings, such as Crisis Stabilization Units (CSUs),[28] and longer-term residential treatment facilities.[29] The goal is to offer intensive therapeutic interventions in a less restrictive environment, facilitating stabilization and preparation for community reintegration.[30] In practice, SRT programs in Florida operate by admitting adults who require extended, yet less intensive, active psychiatric treatment than what is provided in CSUs.[31] These facilities maintain a nurse on duty at all times and deliver a range of services, including individual and group therapy, medication management, and life skills training. The typical length of stay varies based on individual needs but is generally longer than that of CSUs, allowing for comprehensive stabilization and recovery planning.[32]

The Commission recommends increased capacity for short-term residential treatment facilities for both adults and children.[33]

### *Effect of Proposed Changes*

**Section 7** amends s. 394.875, F.S., to require the DCF to conduct a review every other year to identify counties with a shortage of SRT facilities and requires the AHCA to give priority to licensing SRTs in counties identified in the review.

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[27] Department of Children and Families, *The System of Services and Support – Treatment*, available at https://www.myflfamilies.com/services/samh/treatment-services/AMH/system-of-services-and-support (last visited March 20, 2025).
[28] Section 394.67(5), F.S.; "Crisis Stabilization Unit" means a program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state.
[29] Section 394.67(23), F.S.; "Residential Treatment Facility" means a facility providing residential care and treatment to individuals exhibiting symptoms of mental illness who are in need of a 24-hour-per-day, 7-day-a-week structured living environment, respite care, or long-term community placement.
[30] Agency for Health Care Administration, *Crisis Stabilization Units*, available at https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/hospital-outpatient-services-unit/crisis-stabilization-units (last visited March 20, 2025).
[31] *Id.*
[32] Department of Children and Families, *The System of Servies and Support – Treatment*, available at https://www.myflfamilies.com/services/samh/treatment-services/AMH/system-of-services-and-support (last visited March 20, 2025).
[33] *Supra*, Note 9, p. 28.

**Other**

**Sections 11, 12, 13 and 14** make conforming changes or reenact current law to implement the substantive effects of the bill.

The bill takes effect July 1, 2025.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The bill does not require cities and counties to expend funds or limit their authority to raise revenue or receive state-shared revenues as specified by Article VII, s. 18 of the State Constitution.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None Identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires the use and tracking of the Daily Living Activites-20 Function Assessment Tool. Integrating this tool into operations may require providers to receive system updates, technical support, and staff training. The total cost is indeterminate.

C. Government Sector Impact:

The bill creates the Center for Substance Abuse and Mental Health Research (Center) within the University of South Florida's Louis de la Parte Florida Mental Health Institute (FMHI) to conduct statewide behavioral health research, promote evidence-based

practices, and improve workforce development. The estimated annual cost to operate the new Center is $5 million. The cost breakdown is as follows:

- Research & Data Analysis - $1,250,000
- Treatment & Intervention Development - $1,000,000
- Policy & Public Health Impact - $500,000
- Training & Workforce Development - $750,000
- Community Collaboration & Outreach - $500,000
- Technology & Infrastructure - $500,000
- Administration & Operations - $500,000

The bill also requires the Florida Center for Behavioral Health Workforce (FCBHW) at the FMHI to conduct a biennial workforce supply and demand analysis and develop recruitment and retention strategies for behavioral health professionals. It is likely that the FCBHW would be able to absorb the current requirements of the bill within the existing resources.

This bill could have an indeterminate, yet insignificant fiscal impact on the Department of Children and Families and the Department of Education to conduct reviews identifying effective models of school-based behavioral health access. However, it is anticipated that both departments would be able to absorb the current requirements of the bill within existing resources.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.455, 394.457, 394.459, 394.468, 394.495, 394.659, 394.875, 394.9086, 1004.44, 1006.041, 394.9085, 394.463, 394.4955, and 1001.212.

## 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 Children, Families, and Elder Affairs on March 25, 2025:**
The CS makes the following changes:

- Clarifies that the Agency for Healthcare Administration (ACHA) is the agency responsible for prioritizing the licensure of short-term residential treatment programs;
- Removes duplicative language that put unnecessary added duties on the Louis de la Parte Florida Mental Health Institute;

- Makes a technical language change from "biennial" to "every other year" for clarity; and
- Removes the current language requiring specific action by the facilities to provide medications at discharge and instead:
  - Requires the Department of Children and Families (DCF) to perform a review and evaluation of current discharge procedures, to include specific data related to medication adherence and readmission rates of discharged patients.
  - Requires the DCF, in collaboration with AHCA, submit a report on the evaluation to include findings, policy recommendations, and cost estimates to increase:
    - Medication adherence post-discharge;
    - Access to prescribed behavioral health medications at discharge; and
    - The use of long-acting injectables as a discharge medication.

B. Amendments:

None.

**By** the Committee on Children, Families, and Elder Affairs; and Senator Rouson

586-02858-25 20251620c1

A bill to be entitled

An act relating to mental health and substance use disorders; amending s. 394.455, F.S.; defining the term "person-first language"; amending s. 394.457, F.S.; revising the minimum standards for a mobile crisis response service; amending s. 394.459, F.S.; requiring that an individualized treatment plan be reevaluated within a specified timeframe to ensure the recommended care remains necessary for a patient; amending s. 394.468, F.S.; requiring the Department of Children and Families to review and evaluate the discharge procedures and policies for all receiving facilities; specifying the criteria of such evaluations; requiring the department, in collaboration with the Agency for Health Care Administration, to report its findings to the Governor and the Legislature by a specified date; specifying what must be included in such report; amending s. 394.495, F.S.; requiring the department to reevaluate assessment services at specified intervals to ensure a patient's clinical needs are being met; revising such assessment services' evaluations and screening areas; amending s. 394.659, F.S.; requiring the Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center at the Louis de la Parte Florida Mental Health Institute at the University of South Florida to disseminate certain evidence-based practices and best practices among grantees; amending s. 394.875, F.S.; requiring the Department of Children







586-02858-25 20251620c1

and Families, in consultation with the Agency for Health Care Administration, to conduct a review every other year to identify certain counties that require additional resources for short-term residential treatment facilities; requiring the agency to prioritize specified facilities in issuing licenses; amending s. 394.9086, F.S.; revising the duties of the Commission on Mental Health and Substance Use Disorder; amending s. 1004.44, F.S.; revising the requirements of the Florida Center for Behavioral Health Workforce to promote behavioral health professions; creating the Center for Substance Abuse and Mental Health Research within the institute; specifying the purpose of the center; specifying the goals of the center; specifying the responsibilities of the center; requiring the center to submit a report by a specified date each year to the Governor and the Legislature; specifying the contents of the report; amending s. 1006.041, F.S.; revising the plan components for mental health assistance programs; requiring the Department of Children and Families, in consultation with the Department of Education, to conduct a review every other year to identify effective models of school-based behavioral health access; requiring the Department of Children and Families to submit its findings to the Governor and the Legislature by a specified date every other year; amending s. 394.9085, F.S.; conforming a cross-reference; reenacting s. 394.463(2)(g), F.S., relating

to involuntary examination, to incorporate the amendment made to s. 394.468, F.S., in a reference thereto; reenacting s. 394.4955(2)(c) and (6), F.S., relating to coordinated system of care and child and adolescent mental health treatment and support, to incorporate the amendment made to s. 394.495, F.S., in references thereto; reenacting s. 1001.212(7), F.S., relating to the Office of Safe Schools, to incorporate the amendment made to s. 1004.44, F.S., in a reference thereto; providing an effective date.

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

Section 1. Present subsections (33) through (50) of section 394.455, Florida Statutes, are redesignated as subsections (34) through (51), respectively, and a new subsection (33) is added to that section, to read:

394.455 Definitions.—As used in this part, the term:

(33) "Person-first language" means language used in a professional medical setting which emphasizes the patient as a person rather than his or her disability or illness.

Section 2. Paragraph (c) of subsection (5) of section 394.457, Florida Statutes, is amended to read:

394.457 Operation and administration.—

(5) RULES.—

(c) The department shall adopt rules establishing minimum standards for services provided by a mental health overlay program or a mobile crisis response service. Minimum standards for a mobile crisis response service must:





1. Include the requirements of the child, adolescent, and young adult mobile response teams established under s. 394.495(7) and ensure coverage of all counties by these specified teams; ~~and~~

2. Ensure access to mobile response services for persons 65 years of age or older; and

3. Create a structure for general mobile response teams which focuses on crisis diversion and the reduction of involuntary commitment under this chapter. The structure must require, but need not be limited to, the following:

a. Triage and rapid crisis intervention within 60 minutes;

b. Provision of and referral to evidence-based services that are responsive to the needs of the individual and the individual's family;

c. Screening, assessment, early identification, and care coordination; ~~and~~

d. Sharing of best practices with medical professionals, including the use of person-first language and trauma-responsive care, to improve patient experiences and outcomes and encourage cooperative engagement from patients seeking treatment; and

e. Confirmation that the individual who received the mobile crisis response was connected to a service provider and prescribed medications, if needed.

Section 3. Paragraph (e) of subsection (2) of section 394.459, Florida Statutes, is amended to read:

394.459 Rights of patients.—

(2) RIGHT TO TREATMENT.—

(e) Not more than 5 days after admission to a facility, each patient must ~~shall~~ have and receive an individualized

treatment plan in writing which the patient has had an opportunity to assist in preparing and to review before ~~prior to~~ its implementation. The plan must ~~shall~~ include a space for the patient's comments. An individualized treatment plan must be reevaluated no less than every 6 months to ensure the treatment plan's recommended care remains necessary for the patient.

Section 4. Subsection (4) is added to section 394.468, Florida Statutes, to read:

394.468 Admission and discharge procedures.—

(4) The department shall review the discharge procedure for all receiving facilities and evaluate current policy, strategies, and actions taken to meet the need for access to prescribed behavioral health medications at discharge. The evaluation shall include data related to medication adherence and readmission rates of discharged patients. The department shall, in collaboration with the Agency for Health Care Administration, report its findings from the evaluation and provide actionable policy recommendations and cost estimates to increase medication adherence of patients after discharge, increase access to prescribed behavioral health medications for uninsured and underinsured patients at discharge, and increase the use of long-acting injectables as a discharge medication. The report must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2025.

Section 5. Subsection (2) of section 394.495, Florida Statutes, is amended to read:

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





(2) The array of services must include assessment services that provide a professional interpretation of the nature of the problems of the child or adolescent and his or her family; family issues that may impact the problems; additional factors that contribute to the problems; and the assets, strengths, and resources of the child or adolescent and his or her family. The assessment services to be provided must ~~shall~~ be determined by the clinical needs of each child or adolescent. The department shall reevaluate the services no less than every 6 months to ensure the child's clinical needs are being met. Assessment services include, but are not limited to, evaluation and screening in the following areas:

(a) Physical and mental health for purposes of identifying medical and psychiatric problems.

(b) Psychological functioning, as determined through a battery of psychological tests.

(c) Intelligence and academic achievement.

(d) Social and behavioral functioning.

(e) Family functioning.

(f) Functional daily living through the implementation of the Daily Living Activities-20 functional assessment tool as described in s. 1006.041(2)(b).

The assessment for academic achievement is the financial responsibility of the school district. The department shall cooperate with other state agencies and the school district to avoid duplicating assessment services.

Section 6. Paragraph (d) of subsection (1) of section 394.659, Florida Statutes, is amended to read:

394.659 Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center.—

(1) There is created a Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center at the Louis de la Parte Florida Mental Health Institute at the University of South Florida, which shall:

(d) Disseminate and share evidence-based practices and best practices among grantees, including, but not limited to, the use of person-first language and trauma-responsive care, to improve patient experiences and outcomes and encourage cooperative engagement for patients seeking treatment.

Section 7. Subsection (11) is added to section 394.875, Florida Statutes, and paragraph (c) of subsection (1) and paragraph (a) of subsection (8) of that section are republished, to read:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(1)

(c) The purpose of a residential treatment center for children and adolescents is to provide mental health assessment and treatment services pursuant to ss. 394.491, 394.495, and 394.496 to children and adolescents who meet the target population criteria specified in s. 394.493(1)(a), (b), or (c).

(8)(a) The department, in consultation with the agency, must adopt rules governing a residential treatment center for children and adolescents which specify licensure standards for: admission; length of stay; program and staffing; discharge and discharge planning; treatment planning; seclusion, restraints,





and time-out; rights of patients under s. 394.459; use of psychotropic medications; and standards for the operation of such centers.

(11) The department, in consultation with the agency, shall conduct a review every other year to identify counties that require additional resources for short-term residential treatment facilities. The agency shall give priority in issuing licenses to short-term residential treatment facilities located in counties identified by the review.

Section 8. Paragraph (a) of subsection (4) of section 394.9086, Florida Statutes, is amended to read:

394.9086 Commission on Mental Health and Substance Use Disorder.—

(4) DUTIES.—

(a) The duties of the Commission on Mental Health and Substance Use Disorder include the following:

1. Conducting a review and evaluation of the management and functioning of the existing publicly supported mental health and substance use disorder systems and services in the department, the Agency for Health Care Administration, and all other departments which administer mental health and substance use disorder services. Such review must ~~shall~~ include, at a minimum, a review of current goals and objectives, current planning, services strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.

2. Considering the unique needs of persons who are dually diagnosed.

3. Addressing access to, financing of, and scope of

responsibility in the delivery of emergency behavioral health care services.

4. Addressing the quality and effectiveness of current mental health and substance use disorder services delivery systems, and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers, such as community mental health centers; community substance use disorder agencies; hospitals, including emergency services departments; law enforcement agencies; and the judicial system.

5. Addressing priority population groups for publicly funded mental health and substance use disorder services~~;~~, identifying the comprehensive mental health and substance use disorder services delivery systems~~;~~ mental health and substance use disorder needs assessment and planning activities, including, but not limited to, the use of the Daily Living Activities-20 functional assessment tool as described in s. 1006.041(2)(b); and local government funding responsibilities for mental health and substance use disorder services.

6. Reviewing the implementation of chapter 2020-107, Laws of Florida.

7. Identifying any gaps in the provision of mental health and substance use disorder services.

8. Providing recommendations on how behavioral health managing entities may fulfill their purpose of promoting service continuity and work with community stakeholders throughout this state in furtherance of supporting the 988 Suicide and Crisis Lifeline system and other crisis response services.

9. Conducting an overview of the current infrastructure of





the 988 Suicide and Crisis Lifeline system.

10. Analyzing the current capacity of crisis response services available throughout this state, including services provided by mobile response teams and centralized receiving facilities. The analysis must include information on the geographic area and the total population served by each mobile response team along with the average response time to each call made to a mobile response team; the number of calls that a mobile response team was unable to respond to due to staff limitations, travel distance, or other factors; and the veteran status and age groups of individuals served by mobile response teams.

11. Evaluating and making recommendations to improve linkages between the 988 Suicide and Crisis Lifeline infrastructure and crisis response services within this state.

12. Identifying available mental health block grant funds that can be used to support the 988 Suicide and Crisis Lifeline and crisis response infrastructure within this state, including any available funding through opioid settlements or through the American Rescue Plan Act of 2021, Pub. L. No. 117-2; the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136; or other federal legislation.

13. In consultation with the Agency for Health Care Administration, identifying sources of funding available through the Medicaid program specifically for crisis response services, including funding that may be available by seeking approval of a Section 1115 waiver submitted to the Centers for Medicare and Medicaid Services.

14. Making recommendations regarding the mission and

objectives of state-supported mental health and substance use disorder services and the planning, management, staffing, financing, contracting, coordination, and accountability mechanisms which will best foster the recommended mission and objectives.

15. Evaluating and making recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, substance use disorder, and related services statewide. At a minimum, the evaluation must consider and describe the:

a. Specific duties and organizational structure proposed for the entity;

b. Resource needs of the entity and possible sources of funding;

c. Estimated impact on access to and quality of services;

d. Impact on individuals with behavioral health needs and their families, both those currently served through the affected systems providing behavioral health services and those in need of services; and

e. Relation to, integration with, and impact on providers, managing entities, communities, state agencies, and systems which provide mental health and substance use disorder services in this state. Such recommendations must ensure that the ability of such other agencies and systems to carry out their missions and responsibilities is not impaired.

16. Evaluating and making recommendations regarding skills-based training that teaches participants about mental health and substance use disorder issues, including, but not limited to, Mental Health First Aid models.





Section 9. Paragraph (a) of subsection (6) of section 1004.44, Florida Statutes, is amended, and subsection (8) is added to that section, to read:

1004.44 Louis de la Parte Florida Mental Health Institute.—There is established the Louis de la Parte Florida Mental Health Institute within the University of South Florida.

(6)(a) There is established within the institute the Florida Center for Behavioral Health Workforce. The purpose of the center is to support an adequate, highly skilled, resilient, and innovative workforce that meets the current and future human resources needs of the state's behavioral health system in order to provide high-quality care, services, and supports to Floridians with, or at risk of developing, behavioral health conditions through original research, policy analysis, evaluation, and development and dissemination of best practices. The goals of the center are, at a minimum, to research the state's current behavioral health workforce and future needs; expand the number of clinicians, professionals, and other workers involved in the behavioral health workforce; and enhance the skill level and innovativeness of the workforce. The center shall, at a minimum, do all of the following:

1. Describe and analyze the current workforce and project possible future workforce demand, especially in critical roles, and develop strategies for addressing any gaps. The center's efforts may include, but need not be limited to, producing a statistically valid biennial analysis of the supply and demand of the behavioral health workforce.

2. Expand pathways to behavioral health professions through enhanced educational opportunities and improved faculty

development and retention. The center's efforts may include, but need not be limited to:

a. Identifying best practices in the academic preparation and continuing education of behavioral health professionals.

b. Facilitating and coordinating the development of academic-practice partnerships that support behavioral health faculty employment and advancement.

c. Developing and implementing innovative projects to support the recruitment, development, and retention of behavioral health educators, faculty, and clinical preceptors.

d. Developing distance learning infrastructure for behavioral health education and the evidence-based use of technology, simulation, and distance learning techniques.

3. Promote behavioral health professions. The center's efforts may include, but need not be limited to:

a. Conducting original research on the factors affecting recruitment, retention, and advancement of the behavioral health workforce, such as designing and implementing a longitudinal study of the state's behavioral health workforce.

b. Developing and implementing innovative projects to support the recruitment, development, and retention of behavioral health workers.

4. Analyze compensation and benefit data every other year to identify factors that have led to the shortage of behavioral health workers in this state and make recommendations for funding programs to support the growth and retention of the behavioral health workforce, such as stipends or other financial support for clinical supervisors, workers, interns, and students currently working in the field of behavioral health.





5. Request from the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, and the board must provide to the center upon its request, any information held by the board regarding the clinical social work, marriage and family therapy, and mental health counselors licensed in this state or information reported to the board by employers of such counselors, other than personal identifying information.

6. Develop and routinely analyze a behavioral health workforce survey to increase insight into service provision and access, inform priorities that support retention, strategically address critical gaps, and inform workforce-related policy decisions. In conjunction with the Department of Health, the center shall conduct the survey at the time of initial licensure and license renewal for psychologists licensed under chapter 490 and social workers, marriage and family therapists, and mental health counselors licensed under chapter 491. The survey must solicit information including, but not limited to:

a. The frequency and geographic location of practice.

b. Participation in interjurisdictional practice and percentage of Florida and non-Florida residents served.

c. Practice setting and populations served, including availability for critically needed services.

d. Percentage of time spent in direct patient care.

e. Compensation and benefits.

f. Anticipated change to license or practice status.

(8)(a) There is created within the institute the Center for Substance Abuse and Mental Health Research. The purpose of the center is to conduct rigorous and relevant research intended to develop knowledge and practice in prevention and intervention

for substance abuse and mental health issues, to serve the people and economy in this state in reducing the gap between population needs and the availability of effective treatments and other interventions to improve the capacity of the state to have healthy, resilient communities prevailing over substance abuse, addiction, and mental health challenges.

(b) The goals of the center are, at a minimum, to advance the scientific understanding of the relationship between substance abuse and mental health issues, to improve treatment outcomes, and to reduce the societal impact and burden of substance abuse and mental health conditions. The center shall, at a minimum, do all of the following:

1. Analyze publicly funded substance abuse and mental health services to identify gaps in insurance coverage, monitor quality of care and cost management, and enhance provider networks by identifying gaps in service provision by type and geographic location.

2. Research and study the complex relationship between substance abuse and mental health disorders, including analyzing how substances may contribute to the onset of mental health conditions, how those conditions can lead to substance abuse, and how both can interact to create and worsen negative outcomes, such as violence, infectious disease, suicide, and overdose. The center must also study the range, distribution, and concentration of such negative outcomes.

3. Develop and test strategies to prevent the development of both substance use and mental health disorders, including early risk factor identification and interventions designed for at-risk populations, specifically in rural settings, where





resources may be limited and integrated care is essential.

4. Conduct research on alternative, low-cost strategies for prevention and early intervention.

5. Conduct outcomes and implementation research on optimizing application of technology for efficient and effective dissemination of evidence-based treatment across this state, with specific attention to rural and other low-resource areas, using telehealth, mobile device remote monitoring, delivery of patient-specific prompts via technology platforms for self-management, and other aspects of care.

6. Investigate and improve treatment options for individuals suffering from co-occurring substance use and mental health disorders, including developing integrated treatment programs that address both issues simultaneously.

7. Generate evidence-based data to inform public policy and promote substance use disorder services and mental health disorder services.

8. Develop community-based sharing agreements, local infrastructure, and methodologies to encourage data-informed decisionmaking to encourage economic efficiency and targeted service delivery.

9. Develop and provide training for health care professionals, social workers, counselors, and researchers on the latest findings related to substance abuse and mental health, fostering a workforce capable of providing effective care.

10. Articulate methods to align and adapt training approaches for delivering evidence-based practices to locally identified needs, including implementing evidence-based training

and tools at community health centers to improve identification of mental health and substance use disorders and create plans for referral and continuity of care.

11. Collaborate with community organizations to offer resources and education about substance use and mental health to reduce stigma and raise awareness.

(c) By July 1 of each year, the center shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives providing details of its activities during the preceding calendar year in pursuit of its goals and in the execution of its duties under paragraph (b).

Section 10. Paragraph (b) of subsection (2) of section 1006.041, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

1006.041 Mental health assistance program.—Each school district must implement a school-based mental health assistance program that includes training classroom teachers and other school staff in detecting and responding to mental health issues and connecting children, youth, and families who may experience behavioral health issues with appropriate services.

(2) A plan required under subsection (1) must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care. At a minimum, the plan must





include all of the following components:

(b) Contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide a behavioral health staff presence and services at district schools. Services may include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided on or off the school campus and may be supplemented by telehealth as defined in s. 456.47(1). In addition to the services in this paragraph, the department shall implement the Daily Living Activities-20 (DLA-20) functional assessment tool to further assist providers in creating recommended treatment plans. The department shall review the DLA-20 functional assessment tool every other year to implement the most updated version. The department is authorized to replace the DLA-20 functional assessment tool if it determines that a better alternative is available.

(5) The Department of Children and Families, in consultation with the Department of Education, shall conduct a review every other year to identify effective models of school-based behavioral health access, with an emphasis on underserved and rural communities. Such models must include, but are not limited to, telehealth services. The Department of Children and Families shall submit its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1 every other year, beginning in

2026.

Section 11. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms "detoxification," "addictions receiving facility," and "receiving facility" have the same meanings as those provided in ss. 397.311(27)(a)4., 397.311(27)(a)1., and 394.455 ~~394.455(40)~~, respectively.

Section 12. For the purpose of incorporating the amendment made by this act to section 394.468, Florida Statutes, in a reference thereto, paragraph (g) of subsection (2) of section 394.463, Florida Statutes, is reenacted to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(g) The examination period must be for up to 72 hours and begins when a patient arrives at the receiving facility. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. Within the examination period, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the





patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court or with the county court, as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. The petition shall be filed by one of the petitioners specified in s. 394.467, and the court shall dismiss an untimely filed petition. If a patient's 72-hour examination period ends on a weekend or holiday, including the hours before the ordinary business hours on the morning of the next working day, and the receiving facility:

a. Intends to file a petition for involuntary services, such patient may be held at the facility through the next working day thereafter and the petition must be filed no later than such date. If the facility fails to file the petition by the ordinary close of business on the next working day, the patient shall be released from the receiving facility following approval pursuant to paragraph (f).

b. Does not intend to file a petition for involuntary services, the receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge planning and procedures in accordance with s. 394.468, and approval pursuant to paragraph (f), are not possible until the next working day.

Section 13. For the purpose of incorporating the amendment made by this act to section 394.495, Florida Statutes, in references thereto, paragraph (c) of subsection (2) and

subsection (6) of section 394.4955, Florida Statutes, are reenacted to read:

394.4955 Coordinated system of care; child and adolescent mental health treatment and support.—

(2)

(c) To the extent permitted by available resources, the coordinated system of care shall include the array of services listed in s. 394.495.

(6) The managing entity shall identify gaps in the arrays of services for children and adolescents listed in s. 394.495 available under each plan and include relevant information in its annual needs assessment required by s. 394.9082.

Section 14. For the purpose of incorporating the amendment made by this act to section 1004.44, Florida Statutes, in a reference thereto, subsection (7) of section 1001.212, Florida Statutes, is reenacted to read:

1001.212 Office of Safe Schools.—There is created in the Department of Education the Office of Safe Schools. The office is fully accountable to the Commissioner of Education. The office shall serve as a central repository for best practices, training standards, and compliance oversight in all matters regarding school safety and security, including prevention efforts, intervention efforts, and emergency preparedness planning. The office shall:

(7) Provide data to support the evaluation of mental health services pursuant to s. 1004.44. Such data must include, for each school, the number of involuntary examinations as defined in s. 394.455 which are initiated at the school, on school transportation, or at a school-sponsored activity and the number





of children for whom an examination is initiated.

Section 15. This act shall take effect July 1, 2025.

The Florida Senate

# APPEARANCE RECORD

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

4/10/25
Meeting Date

Approps on Health & Human Services
Committee

SB1620
Bill Number or Topic

Amendment Barcode (if applicable)

Name Lauren Hartmann

Phone 727-743-6220

Address 4202 E Fowler Ave.
Street

Email lhartmann@usf.edu

Tampa FL 33602
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

☐ 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

4/10/25
Meeting Date

HHS APPROPRIATION
Committee

SB 1620
Bill Number or Topic

Amendment Barcode (if applicable)

Name NATALIE KELLY

Phone (850) 895-1313

Address 122 S. CALHOUN
Street

Email NATALIE@FLMANAGINGENTITIES.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 ASSOCIATION OF MANAGING ENTITIES

☐ 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/CS/SB 1736 |
| INTRODUCER: | Appropriations Committee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senators Grall and Sharief |
| SUBJECT: | Insulin Administration by Direct-support Professionals and Relatives |
| DATE: | April 14, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Rao | Tuszynski | CF | **Fav/CS** |
| 2. | Howard | McKnight | AHS | **Fav/CS** |
| 3. | | | RC | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/CS/SB 1736 creates s. 393.504, F.S., to allow direct-support professionals or a client's relative to administer insulin in an Agency for Persons with Disabilities licensed group home facility to a client with a developmental disability.

The bill defines the term "direct-support professional" to refer to an individual paid to provide services directly to a client with developmental disabilities that receives home and community-based services.

The bill allows direct-support professionals or relatives to administer insulin in group home facilities if the group home facility provides training, and adopts policies and procedures governing the administration of insulin by direct-support professionals or relatives.

The bill provides immunity from civil liability to group home facilities that are compliant with the requirements for the administration of insulin. The bill also provides civil and criminal immunity to direct-support professionals or relatives arising out of the administration of insulin in group home facilities, so long as the direct-support professional or relative were compliant with the requirements of administration.

The bill provides that the administration of insulin by a direct-support professional or relative in a group home facility includes sliding scale insulin therapy.

The bill adds subcutaneous administration of insulin and epinephrine by self-administration devices to existing law that allows an unlicensed direct service provider to supervise the self-administration of medication.

The bill is expected to have an insignificant, negative fiscal impact on state expenditures. **See Section V., Fiscal Impact Statement.**

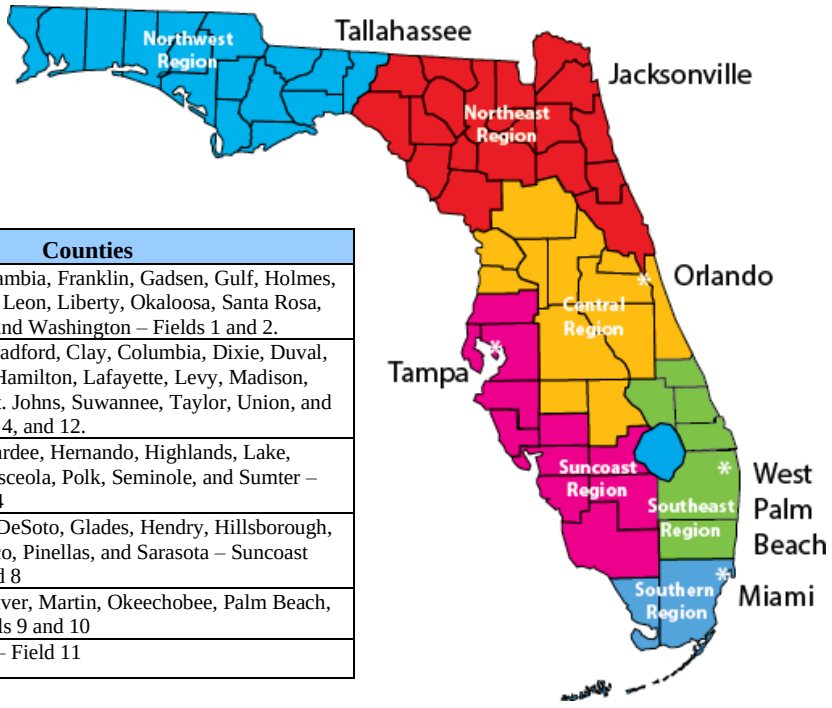
The bill takes effect July 1, 2025.

## II. Present Situation:

### Agency for Persons with Disabilities — Generally

Chapter 393, F.S., identifies the need to provide community-based services and programs for individuals with developmental disabilities that enable individuals to achieve their greatest potential for independent living while reducing the number of individuals in unnecessary institutional placements.[1]

The Agency for Persons with Disabilities (APD) provides services to individuals with developmental disabilities and manages Medicaid waivers that provide federally approved services for individuals with developmental disabilities.[2] In addition to central headquarters in Tallahassee, the APD operates a total of six regional offices and 14 field offices throughout the state, as detailed below:[3]




| Regions | Counties |
|---|---|
| **Northwest** | Bay, Calhoun, Escambia, Franklin, Gadsen, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Walton, and Washington – Fields 1 and 2. |
| **Northeast** | Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Madison, Nassau, Putnam, St. Johns, Suwannee, Taylor, Union, and Volusia – Fields 3, 4, and 12. |
| **Central** | Brevard, Citrus, Hardee, Hernando, Highlands, Lake, Marion, Orange, Osceola, Polk, Seminole, and Sumter – Fields 7, 13, and 14 |
| **Suncoast** | Charlotte, Collier, DeSoto, Glades, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, and Sarasota – Suncoast Field (23) and Field 8 |
| **Southeast** | Broward, Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie – Fiels 9 and 10 |
| **Southern** | Dade and Monroe – Field 11 |

[1] Section 393.062, F.S.
[2] Section 20.197, F.S.
[3] Agency for Persons with Disabilities, *Regional Offices*, available at: https://apd.myflorida.com/region/ (last visited March 11, 2025).

### *Agency for Persons with Disability - Licensed Placement Array*

The APD is required to license facilities and adult day training programs for individuals with developmental disabilities.[4] The APD licenses the following facilities, which provide an array of services for individuals with developmental disabilities:[5]

| Licensed Placements for Individuals with Developmental Disabilities | |
|---|---|
| **Facility** | **Description** |
| Foster Care Facility | A residential facility licensed under ch. 393, F.S. that provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility may not be more than three residents. [6] |
| Group Home Facility | A residential facility licensed under ch. 393, F.S. which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility must be at least 4 but not more than 15 residents.[7] |
| Residential Habilitation Center | A community residential facility licensed under ch. 393, F.S. which provides habilitation services. The capacity of such a facility may not be fewer than nine residents. After October 1, 1989, new residential habilitation centers may not be licensed and the licensed capacity for any existing residential habilitation center may not be increased[8] |
| Adult Day Training Program | A program of services which takes place in a nonresidential setting, separate from the home or facility in which the client resides, and is intended to support the participation of clients in meaningful and valued routines of the community. These services include, but are not limited to, the acquisition, retention, or improvement of self-help, socialization, and adaptive skills.[9] |

The APD is required to adopt license application procedures, provider qualifications, facility and client care standards, requirements for client records, requirements for staff qualifications and training, and requirements for monitoring the licensed placements.[10] The APD is required to adopt rules relating to the oversight and accountability of such placements.[11] If the licensee fails to comply with licensure or statutory requirements, Florida law authorizes the APD to take disciplinary action against the licensee, such as the revocation or suspension of a licensing, or the imposition of administrative fines.[12]

### *Administration of Medication in APD Licensed Facilities*

Florida law allows an unlicensed direct service provider to supervise the self-administration of medication or to administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications to a client, provided the unlicensed direct service providers meets

[4] Section 393.067, F.S.
[5] *See generally* 65G-2, F.A.C.
[6] Section 393.063(17), F.S.
[7] Section 393.063(18), F.S.
[8] Section 393.063(34), F.S.
[9] Section 393.063(1), F.S.
[10] Section 393.067, F.S.
[11] Section 393.067, F.S.
[12] Section 393.0673, F.S.

statutory requirements.[13] Unlicensed direct service providers who have completed an APD-approved training course and have current validation to provide clients with medication administration or assist clients with self-administration of medication are referred to as Medication Assistance Providers under administrative rule.[14] Medical Case Managers[15] teach Basic Medication Administration Courses to unlicensed direct service providers.[16] Currently, administrative rule does not reference medication administration by non-paid family members.[17]

Medication Assistance Providers are not allowed to prepare syringes for a client's use during the self-administration of medication via a subcutaneous, intra-dermal, intra-muscular, or intravenous route.[18] Syringes, insulin pens, and insulin pumps administer insulin subcutaneously.[19] Currently, licensed nurses are the only individuals who are allowed to administer insulin in APD facilities.[20]

Upon a medication error, the Medical Assistance Provider or facility administrator is required to document the incident in a procedure identified in administrative rule.[21]

There is no reference to insulin administration in 65G-7, F.A.C., which establishes the requirements for Medication Administration in APD facilities.[22]

***Diabetes***

Diabetes occurs when an individual's blood glucose, or blood sugar, is too high.[23] High blood glucose may lead to negative effects on an individual's heart, nerve, eye, and kidney function.[24] An individual receives blood glucose through the food he or she eats, and the hormone insulin, produced by the pancreas, assists blood glucose absorption into the cells to produce energy. [25]

[13] Section 393.506, F.S.
[14] 65G-7.001, F.A.C.
[15] "Medical Case Managers" refer to a registered nurse or Advanced Practice Nurse Practitioner employed by the Agency to provide nursing consultation and technical assistance to an Area office regarding the medical care of Agency clients. *See* 65G-7.001, F.A.C.
[16] Florida Agency for Persons with Disabilities, *2025 Agency Analysis,* pg. 2, on file with the Senate Committee on Children, Families, and Elder Affairs.
[17] *Id.*
[18] 65G-7.005, F.A.C.
[19] Shah, Rima B. et al. "Insulin delivery methods: Past, Present, and Future." *International Journal of Pharmaceutical Investigation* vol. 6, 1 (2016): 1-9. doi: 10.4103/2230-973X.176456.
[20] *Supra,* Note 16.
[21] 65G-7.006, F.A.C.
[22] 65G-7.001, F.A.C.
[23] National Institute of Diabetes and Digestive and Kidney Diseases, *Diabetes Statistics*, available at: https://www.niddk.nih.gov/health-information/health-statistics/diabetes-statistics (last visited March 14, 2025).
[24] *Id.*
[25] National Institute of Diabetes and Digestive and Kidney Diseases, *Type 2 Diabetes*, available at: https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes/type-2-diabetes (last visited March 14, 2025).

An individual with diabetes may have trouble producing the insulin necessary to help glucose absorption. The most common types of diabetes are type 1, type 2, and gestational diabetes, which affects individuals during pregnancy.[26]

Type 1 diabetes typically occurs when an individual's immune system attacks and destroys the cells in the pancreas responsible for producing insulin, causing the pancreas to cease insulin production.[27] This causes abnormal levels of blood glucose, as the glucose cannot absorb into the cells and remains in an individual's blood.[28] An individual with type 1 diabetes will take synthetic insulin every day to facilitate the absorption of blood glucose into an individual's cells.[29]

Type 2 diabetes occurs when an individual's pancreas does not produce enough insulin or does not utilize insulin well.[30]

***Insulin Types and Administration***

There are a variety of insulin types an individual may take to manage their diabetes.[31] The following chart shows different types of insulin[32]

| **Insulin Types** | | | | |
|---|---|---|---|---|
| **Insulin Type** | **Onset** | **Peak Time** | **Duration** | **Method** |
| Rapid acting | 15 minutes | 1 hour | 2 to 4 hours | Usually taken right before a meal. Often used with longer-acting insulin. |
| Rapid-acting inhaled | 10 to 15 minutes | 30 minutes | 3 hours | Usually taken right before a meal. Often used with injectable long-acting insulin. |
| Regular/short acting | 30 minutes | 2 to 3 hours | 3 to 6 hours | Usually taken 30 to 60 minutes before a meal. |
| Intermediate acting | 2 to 4 hours | 4 to 12 hours | 12 to 18 hours | Covers insulin needs for half a day or overnight. Often used with rapid- or short-acting insulin. |
| Long acting | 2 hours | Does not peak | Up to 24 hours | Covers insulin needs for about a full day. Often used, when needed, with rapid- or short-acting insulin. |
| Ultra-long acting | 6 hours | Does not peak | 36 hours or longer | Provides steady insulin for long periods. |
| Premixed | 5 to 60 minutes | Peaks vary | 10 to 16 hours | Combines intermediate- and short-acting insulin. Usually taken 10 to 30 minutes before breakfast and dinner. |

[26] National Institute of Diabetes and Digestive and Kidney Diseases, *Diabetes Statistics*, available at: https://www.niddk.nih.gov/health-information/health-statistics/diabetes-statistics (last visited March 14, 2025).
[27] National Institute of Diabetes and Digestive and Kidney Diseases, *Type 1 Diabetes*, available at: https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes/type-1-diabetes (last visited March 14, 2025).
[28] *Id.*
[29] *Id.*
[30] National Institute of Diabetes and Digestive and Kidney Diseases, *Type 2 Diabetes*, available at: https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes/type-2-diabetes (last visited March 14, 2025).
[31] Center for Disease Control Diabetes, *Types of Insulin*, available at: https://www.cdc.gov/diabetes/about/how-to-use-insulin.html (last visited March 14, 2025).
[32] Center for Disease Control Diabetes, *Types of Insulin*, available at: https://www.cdc.gov/diabetes/about/how-to-use-insulin.html (last visited March 14, 2025).

*Source: Center for Disease Control*

Individuals often take insulin differently depending on the type of insulin they use and what method they are most comfortable with when administering insulin. The following chart displays common methods for administering insulin:[33]

| Insulin Administration Methods | |
|---|---|
| **Method** | **Description** |
| Syringe | This method delivers insulin through a needle. This is often referred to as "sliding-scale" administration as the amount needed (the bolus) is calculated based on the current blood glucose level and drawn from a container into a syringe and then administered subcutaneously. |
| Insulin Pen | Cartridges may be inserted into an insulin pen for insulin administration. Some insulin pens are pre-filled and single use. The insulin is injected through a needle. |
| Insulin Pump | Insulin pumps give an individual a dose of short- or rapid-acting insulin per hour. An individual calculates the insulin dosage, and the insulin in the pump delivers the bolus (short- or rapid-acting insulin take at or before mealtimes).<br><br>The pump delivers insulin through a thin plastic tube placed in the fatty layer under an individual's skin. |
| Insulin Inhaler | An individual uses an oral inhaler to deliver ultra-rapid-acting insulin at the beginning of meals. Inhaled insulin is used with an injectable long-acting insulin. |

### *Auto-Injectors for Medication Administration*

In recent years, there has been an increased interest in auto injectors for the self-administration of medication in the medical community.[34] Generally, auto injectors are prefilled with an individual's required dosage of medication (such as insulin or epinephrine) and the individual presses a button or pushes against the injection site to deliver the dosage subcutaneously.[35] Auto injectors have been found to provide an individual more autonomy and flexibility when self-administering their medication.[36] Additionally, auto injectors have been associated with less painful medication administration.[37]

## III. Effect of Proposed Changes:

**Section 1** amends s. 393.063, F.S., to define the term "direct-support professional" to mean a person who is paid to provide services directly to a client with developmental disabilities that receives home and community-based services to address activities of daily living or instrumental

[33] Center for Disease Control Diabetes, *4 Ways to Take Insulin*, available at: https://www.cdc.gov/diabetes/about/4-ways-to-take-insulin.html (last visited March 14, 2025).
[34] Schneider, et al. (2023). Autoinjectors for large-volume subcutaneous drug delivery: a review of current research and future directions. *Expert Opinion on Drug Delivery*, 20(6), 815-830. https://doi.org/10.1080/17425247.2023.2219891
[35] *Id.*
[36] Berteau, et al. (2010) Evaluation of performance, safety, subject acceptance, and compliance of a disposable autoinjector for subcutaneous injections in healthy volunteers, *Patient Preference and Adherence*, 4, 379-288, https://doi.org/10.2147/ppa.s13132.
[37] *Id.*

activities of daily living, behavioral supports, employment supports, or other services to promote community integration of the client.

**Section 2** creates s. 393.504, F.S., to allow a direct-support professional (DSP) or a client's relative to administer insulin to a client in a group home facility if the group home facility has established training procedures and has adopted policies and procedures governing the administration of insulin by DSP and relatives. The term "relative" is defined in s. 393.063(30), F.S., and refers to an individual who is connected by affinity or consanguinity to the client and who is 18 years of age or older.

If a group home facility wants to allow a DSP or relative to administer insulin, the bill requires the group home facility to have an established procedure to provide training to the DSP or relative in the administration of insulin. This training must be provided by:

- A registered nurse, a licensed practical nurse, or an advanced practice registered nurse licensed under ch. 464, F.S.;
- A physician licensed under ch. 458, F.S., or ch. 459, F.S.; or
- A physician assistant licensed under ch. 458, F.S., or ch. 459, F.S.

The bill requires the group home facility to adopt policies and procedures governing the administration of insulin by direct-support professionals and relatives, which must include, but need not be limited to, the following:

- Requirements to have the client's prescribed dosage of insulin required for the client and proof of the direct-support professional's or relative's training on file.
- Coordination procedures in place between the group home facility and direct-support professional or relative to avoid duplication in insulin administration.
- Established emergency procedures related to the administration of insulin to clients.
- Certifications for direct-support professionals or relatives to administer insulin if the individual is in compliance with requirements.
- Requirements for the group home facility to immediately notify a direct-support professional or relative if he or she is not in compliance with these requirements and immediately cease to allow them to administer insulin.

The bill provides compliant group home facilities with immunity from civil liability for damages arising out of the administration of insulin by a direct-support professional or a client's relative.

The bill provides compliant direct-support professionals or relatives with immunity from civil liability or criminal penalties arising out of the administration of insulin to the client.

The bill clarifies that DSPs and relatives may administer insulin including sliding scale insulin therapy, to include the calculation of an insulin dose based on current blood glucose for administration of the dose subcutaneously with an insulin pen or a syringe filled with the calculated dose drawn from a vial of insulin.

**Section 3** amends s. 393.506, F.S., to include, but is not limited to, the subcutaneous administration of insulin and epinephrine through an insulin pen, epinephrine pen, or similar

device designed for self-administration to the administration of medication allowed by unlicensed direct service providers.

**Section 4** amends s. 1002.394, F.S., to make conforming cross-reference changes.

**Section 5** 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 identified.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Agency for Persons with Disabilities (APD) reports the bill will require enhancements to the iConnect system, the APD's client data management and electronic visit verification system, and estimates a cost of $20,000 based on the number of hours it will take to make the necessary modifications to some of the impacted forms in the iConnect system. The APD can absorb these costs within existing resources.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill amends the following sections of the Florida Statutes: 393.063, 393.506, and 1002.394.

This bill creates section 393.504 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.)

**CS/CS by Appropriations Committee on Health and Human Services on April 10, 2025:**
The committee substitute specifies that the inclusion of the subcutaneous administration of insulin and epinephrine through an insulin pen, epinephrine pen, or similar device designed for self-administration to the administration of medication allowed by unlicensed direct service providers is not the only administration of medication method allowed under the law.

**CS by Children, Families, and Elder Affairs on March 19, 2025:**
- Clarifies that the administration of insulin in a group home facility by a direct-support professional or relative includes sliding scale insulin therapy.
- Includes the subcutaneous administration of insulin and epinephrine by a self-administration device in medications that may be self-administered.

B. Amendments:

None.

574242

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/10/2025 | . | |
| | . | |
| | . | |
| | . | |

The Appropriations Committee on Health and Human Services (Grall) recommended the following:

**Senate Amendment**

Delete line 97

and insert:

This includes, but is not limited to, the subcutaneous administration of insulin and

**By** the Committee on Children, Families, and Elder Affairs; and Senator Grall



A bill to be entitled

An act relating to insulin administration by direct-support professionals and relatives; amending s. 393.063, F.S.; defining the term "direct-support professional"; creating s. 393.504, F.S.; authorizing direct-support professionals and relatives of clients in group home facilities for individuals with developmental disabilities to administer insulin as prescribed to the client if specified conditions are met; providing group home facilities, direct-support professionals, and relatives of clients with immunity from civil liability for damages and civil and criminal penalties under certain circumstances; providing that the administration of insulin includes sliding scale insulin therapy; amending s. 393.506, F.S.; authorizing unlicensed direct service providers who meet certain requirements to administer and supervise the self-administration of insulin and epinephrine by certain methods; amending s. 1002.394, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Present subsections (13) through (46) of section 393.063, Florida Statutes, are redesignated as subsections (14) through (47), respectively, and a new subsection (13) is added to that section, to read:

393.063 Definitions.—For the purposes of this chapter, the









term:

(13) "Direct-support professional" means a person paid to provide services directly to a client receiving home and community-based services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration of the client.

Section 2. Section 393.504, Florida Statutes, is created to read:

393.504 Administration of insulin.—

(1) Notwithstanding any other law, a direct-support professional or a client's relative may administer insulin to a client residing in a group home facility if all of the following conditions have been met:

(a) The group home facility has an established procedure to provide training to the direct-support professional or relative in the administration of insulin. The training must be provided by a registered nurse, a licensed practical nurse, or an advanced practice registered nurse licensed under chapter 464; a physician licensed under chapter 458 or chapter 459; or a physician assistant licensed under chapter 458 or chapter 459.

(b) The group home facility has adopted policies and procedures governing the administration of insulin by direct-support professionals and relatives. The policies and procedures must include, but need not be limited to, the following provisions:

1. For clients requiring insulin, the group home facility shall have on file the prescribed dosage of insulin required for the client and proof of the direct-support professional's or

relative's training as required under paragraph (a).

2. The group home facility and the direct-support professional or relative shall coordinate in advance before insulin is administered to the client to avoid duplication in administration.

3. The group home facility shall establish emergency procedures related to the administration of insulin to clients.

4. The group home facility must certify any direct-support professional or relative to administer insulin under this section if he or she is in compliance with the requirements of this section.

5. The group home facility must immediately notify a direct-support professional or relative if he or she is not in compliance with this section and immediately cease to allow them to administer insulin.

(2) A group home facility that complies with this section and its established policies and procedures is immune from civil liability for damages arising out of the administration of insulin by a direct-support professional or a client's relative.

(3) A direct-support professional or relative administering insulin to a client residing in a group home facility in compliance with this section is immune from civil liability for damages or civil or criminal penalties arising out of the administration of insulin to the client.

(4) For the purposes of this section, the administration of insulin includes sliding scale insulin therapy, to include the calculation of an insulin dose based on current blood glucose and the administration of that calculated dose subcutaneously using an insulin pen containing premeasured doses or a syringe





filled with the calculated dose drawn from a vial of insulin.

Section 3. Subsection (1) of section 393.506, Florida Statutes, is amended to read:

393.506 Administration of medication.—

(1) An unlicensed direct service provider may supervise the self-administration of medication or may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications to a client if the unlicensed direct service provider meets the requirements of this section. This includes the subcutaneous administration of insulin and epinephrine through an insulin pen, epinephrine pen, or similar device designed for self-administration.

Section 4. Paragraph (e) of subsection (2) of section 1002.394, Florida Statutes, is amended to read:

1002.394 The Family Empowerment Scholarship Program.—

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

(e) "Disability" means, for a 3- or 4-year-old child or for a student in kindergarten to grade 12, autism spectrum disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association; cerebral palsy, as defined in s. 393.063; Down syndrome, as defined in s. 393.063; an intellectual disability, as defined in s. 393.063; a speech impairment; a language impairment; an orthopedic impairment; any other health impairment; an emotional or a behavioral disability; a specific learning disability, including, but not limited to, dyslexia, dyscalculia, or developmental aphasia; Phelan-McDermid syndrome, as defined in s. 393.063; Prader-Willi syndrome, as defined in s. 393.063; spina bifida, as defined in s. 393.063; being a

high-risk child, as defined in s. 393.063(23)(a) ~~s. 393.063(22)(a)~~; muscular dystrophy; Williams syndrome; rare diseases which affect patient populations of fewer than 200,000 individuals in the United States, as defined by the National Organization for Rare Disorders; anaphylaxis; a hearing impairment, including deafness; a visual impairment, including blindness; traumatic brain injury; hospital or homebound; or identification as dual sensory impaired, as defined by rules of the State Board of Education and evidenced by reports from local school districts. The term "hospital or homebound" includes a student who has a medically diagnosed physical or psychiatric condition or illness, as defined by the state board in rule, and who is confined to the home or hospital for more than 6 months.

Section 5. This act shall take effect July 1, 2025.

The Florida Senate

# Committee Agenda Request

**To:** Senator Jay Trumbull, Chair
Appropriations Committee on Health and Human Services

**Subject:** Committee Agenda Request

**Date:** March 19, 2025

---

I respectfully request that **Senate Bill #1736**, relating to Insulin Administration by Direct-support Professionals and Relatives, 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

The Florida Senate

# APPEARANCE RECORD

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

4/10/2025
Meeting Date

HHS
Committee

SB 1736
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dina Justice, COO, The Arc of Florida

Phone

Address 2898 Mahan Dr Ste 1
Street

Email dina@arcflorida.org

TLH 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: The Arc of Florida

☐ 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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1768 |
| INTRODUCER: | Health Policy Committee and Senator Trumbull |
| SUBJECT: | Stem Cell Therapy |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Smith | Brown | HP | **Fav/CS** |
| 2. | Gerbrandt | McKnight | AHS | **Favorable** |
| 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 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 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 has an indeterminate, yet negative fiscal impact on state expenditures which likely can be absorbed within existing resources. **See Section V., Fiscal Impact Statement.**

The bill takes effect 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 Food and Drug Administration (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 Department of Health (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

[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] Department of Health, Senate Bill 1617 *Legislative Analysis* (Mar. 19, 2025) (on file with the Senate Committee on Health Policy).

BOM further warned that a physician providing stem cell treatment should do so only with an 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** 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 Food and Drug Administration (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.

[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).

- "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.

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 Department of Health (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.

The bill takes effect 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 bill has an indeterminate yet negative fiscal impact on state expenditures. The Department of Health (DOH) will incur nonrecurring costs associated with rulemaking and updating systems, and these costs can be absorbed within existing resources.

According to the DOH, there may be an indeterminate fiscal impact on its Bureau of Enforcement to develop criteria for exemption determinations, monitoring compliance, and investigate violations. These costs can likely be absorbed within existing resources.[10]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 458.3245 and 459.0127.

[10] Department of Health, Senate Bill 1617 *Legislative Analysis* (Mar. 19, 2025) (on file with the Senate Committee on Health Policy).

## 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 Department of Health (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.

**By** the Committee on Health Policy; and Senator Trumbull

588-03144-25 20251768c1

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.

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

Section 1. Section 458.3245, Florida Statutes, is created to read:

458.3245 Stem cell therapy.—







588-03144-25 20251768c1

(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 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.

(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. 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 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 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.

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 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.

(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:

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. 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.

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.

**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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/CS/SB 1800 |
| INTRODUCER: | Appropriations Committee on Health and Human Services; Health Policy Committee; and Senator Calatayud |
| SUBJECT: | Parkinson's Disease |
| DATE: | April 14, 2025 |
| REVISED: | |

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

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/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. 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 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 Board must 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 is subject to legislative appropriation. If an appropriation is provided funds must be allocated as prescribed in the bill. **See Section V., Fiscal Impact Statement.**

The bill takes effect 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, 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.

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[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*.

- 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.

***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]

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[7] 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).

[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] 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).

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.

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 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.

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[10] 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).
[11] *Id*.
[12] *Id*.
[13] 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).
[14] *Id*.
[15] *Id*.

- 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. 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]

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[16] 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).
[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).
[20] Parkinson's Foundation, *Parkinson's Biomarkers, available at* https://www.parkinson.org/understanding-parkinsons/getting-diagnosed/biomarkers (last visited Mar. 30, 2025).
[21] 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).

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 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]

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[22] 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).

[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] 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).

[27] 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).

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 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 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.

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[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 27.

[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).

- 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 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."

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[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).
[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] 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).

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" to mean the Parkinson's Disease Research Board.
- "Consortium" to mean the Consortium for Parkinson's Disease Research.

The bill establishes the Consortium for Parkinson's Disease Research (Consortium), which consists of public and private universities and academic medical centers, within the University of South Florida (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 (Board) to direct the operations of the Consortium. The Board must be composed of members representing each participating university or academic medical center and appointed by the president or chief executive officer of each participating university or academic medical center. 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 vote of the members present is required for all actions of the Board. The Board may prescribe, amend, and repeal a charter governing the way 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. Subject to the approval of the Board, the director must:
- 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 and academic medical center 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** requires the following allocation of funds, subject to appropriation 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.

The bill takes effect 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 bill is subject to legislative appropriation. If an appropriation is provided funds must be allocated as prescribed in the bill:

- 67 percent of funds appropriated are directed to the University of South Florida (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.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

The bill does not speak to how the public or private universities, or academic medical centers are chosen to participate in the Consortium. The bill is silent as to the term of service for the director of the Consortium. The term "academic medical center" is not defined in current law.

## VIII. Statutes Affected:

This bill creates section 1004.4352 of the Florida Statutes.

The bill creates undesignated sections of the Florida law.

## IX. Additional Information:

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

**CS/CS by Appropriations Committee on Health and Human Services on April 10, 2025:**
The committee substitute revises the makeup of the Florida Consortium for Parkinson's Disease Research to include academic medical centers, in addition to public and private universities and revises the makeup of the Parkinson's Disease Research Board to include appointees from academic medical centers.

**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 University of South Florida (USF) and establishes a Parkinson's Disease Research Board (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.

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LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/10/2025 | . | |
| | . | |
| | . | |
| | . | |

The Appropriations Committee on Health and Human Services (Calatayud) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 40 - 69
and insert:
shall be composed of public and private universities and academic medical centers. 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

121756

composed of members representing each participating university or academic medical center, appointed by the president or chief executive officer, respectively, of each participating university or academic medical center. Board members must, collectively, 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 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 and academic medical center

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

121756

And the title is amended as follows:

Delete lines 8 - 10

and insert:

membership and duties of the board; requiring the board to direct the operations of the consortium; providing

**By** the Committee on Health Policy; and Senator Calatayud

588-03164-25 20251800c1

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 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.

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

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:

(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,







588-03164-25 20251800c1

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 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 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.

The Florida Senate

# APPEARANCE RECORD

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

4/10/25
Meeting Date

Approps on HHS
Committee

1800
Bill Number or Topic

Morsani College
Amendment Barcode (if applicable)

Name Donald Mullins - USF of Medicine

Phone 407 455 4788

Address 560 Channelside Dr
Street

Email MULLINSD@USF.EDU

Tampa FL 33602
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

April 10, 2025
Meeting Date

HHS Appropriations
Committee

SB 1800
Bill Number or Topic

Amendment Barcode (if applicable)

Name Gus Corbella

Phone 850-443-8925

Address 101 East College Avenue
*Street*

Email corbella@gtlaw.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:
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)*

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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/SB 1808 |
| INTRODUCER: | Health Policy Committee and Senator Burton |
| SUBJECT: | Refund of Overpayments Made by Patients |
| DATE: | April 9, 2025 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Smith | Brown | HP | **Fav/CS** |
| 2. | Gerbrandt | McKnight | AHS | **Favorable** |
| 3. | | | RC | |

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/SB 1808 requires health care practitioners, facilities, providers, and anyone who accepts payment from insurance for services rendered by health care practitioners, to refund any overpayment made by the patient no later than 30 days after determining that the patient made an overpayment.

Under the bill, if a health care practitioner fails to timely refund an overpayment after he or she determines that an overpayment was made, the failure constitutes grounds for disciplinary action by the applicable board, or the Department of Health if there is no board.

Under the bill, if a facility or provider licensed by the Agency for Health Care Administration fails to timely refund an overpayment, the agency may impose an administrative penalty of up to $500 on the licensee.

The bill's requirement to timely refund such an overpayment does not apply to overpayments made to providers by health insurers and health maintenance organizations, and the bill instead defers to existing law for such cases.

The bill has an indeterminate yet significant negative impact on state expenditures. **See Section V., Fiscal Impact Statement.**

The bill takes effect January 1, 2026.

## II. Present Situation:

### Overpayments in Health Care

Circumstances such as miscalculations, duplicate payments, insurance coverage adjustments, and coding errors can create occasional overpayments by patients to health care providers. When this occurs, it is legally required[1] for the provider to return any excess funds to the patient, although there is no statutory requirement that the overpayment be refunded by a certain date.

For example, the following situations could lead to a health care provider collecting an overpayment and subsequently refunding the overpayment to the patient:

#### *Excess Patient Responsibility Collected*

In some instances, a patient's insurance benefits or deductibles may be miscalculated by either the patient or the health care provider. For example, a clinic might initially collect a copayment or deductible based on an estimate of services rendered. When the insurance claim is later processed, the insurer might pay more than anticipated, resulting in an overpayment on the patient's account. In such cases, the provider is obligated to refund the excess amount to the patient.

#### *Duplicate Payments*

Occasionally, patients or their family members may inadvertently make multiple payments for the same service. This situation can occur when payment is mailed, then followed by an electronic payment or when two different individuals in a household pay the same bill. Once the provider's accounting or billing system detects that the patient's account has been paid more than once for the same service, they may issue a refund of the additional payment.

#### *Insurance Reconciliation Adjustments*

After claims are submitted to an insurance company, subsequent policy adjustments or retroactive changes to coverage may alter the final bill. For instance, if an insurance company conducts an internal audit and determines that a greater portion of the claim should have been covered, they might send an additional reimbursement to the provider. This supplemental payment can create a credit on the patient's account, thereby necessitating a refund of any previously collected balance from the patient.

#### *Billing or Coding Errors*

In rare circumstances, mistakes in billing codes or modifiers lead to inaccurate charges on a patient's account. Such coding discrepancies may not be apparent until the insurance company or the provider's billing department conducts a review. Upon identifying a coding error, such as a charge for a service that was not actually performed, the provider corrects the billing statement and may refund any overpayment to the patient.

[1] A court order would be required to mandate that a patient's overpayment be refunded to the patient. In common law, restitution for an overpayment aims to prevent unjust enrichment by restoring the claimant to their original position, requiring the recipient to return the benefit received, typically money, due to a mistake or other legal basis. *See also* the Florida Deceptive and Unfair Trade Practices Act in part II of ch. 501. F.S.

### *Coordination of Benefits Between Multiple Insurers*

Patients sometimes have two or more sources of insurance coverage (e.g., primary and secondary insurance plans). If both insurers remit payment and inadvertently exceed the cost of the service, the health care provider may receive funds beyond what is contractually called for. Once this overage is discovered, the overpayment may be refunded directly to the patient or appropriately adjusted between the insurers.

## State Regulation of Insurance

The Office of Insurance Regulation (OIR)[2] is responsible for all activities concerning health maintenance organizations (HMOs), health 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.[3] To transact business in Florida, a health insurer or HMO must obtain a certificate of authority from the OIR.[4] The Agency for Health Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[5] As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[6]

### *Payment of Health Insurer and HMO Claims*

The Florida Insurance Code[7] prescribes the rights and responsibilities of health care providers, health insurers, and HMOs for the payment of claims. Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in accordance with ss. 627.6131, 627.662, and 641.3155, F.S., respectively.[8] The law prescribes a protocol for specified providers to use for the submission of their claims to an insurer or HMO, as well as a statutory process for insurers or HMOs to use for the payment or denial of the claims.

Generally, if a health insurer or HMO determines it has made an overpayment to a provider, the insurer's or HMO's claim for the overpayment must be submitted to the provider within 30 months after the applicable payment by the insurer or HMO.[9] A provider must pay, deny, or contest the claim for overpayment of a health insurer or HMO within 40 days after receiving the claim.

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[2] The OIR is a unit under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. Commission members serve as the agency head for purposes of rulemaking under ch. 120, F.S. See s. 20.121(3), F.S.
[3] Section 20.121(3)(a), F.S.
[4] Sections 624.401 and 641.49, F.S.
[5] Section 641.495, F.S.
[6] *Id.*
[7] Pursuant to s. 624.01, F.S., chs. 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code."
[8] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S.
[9] Section 627.6131(6), F.S., and s. 641.3155(5) F.S., for HMO provision.

All contested claims for overpayment must be paid or denied within 120 days after the provider's receipt of the claim.[10] Failure to pay or deny the claim of overpayment within 140 days after receipt creates an uncontestable obligation by the provider to pay the claim.[11] A claim for overpayment is not permitted beyond 30 months after the health insurer's or HMO's applicable payment to the provider, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234, F.S.[12]

Section 627.6131(18), F.S., provides an exception to the period of 30 months for an insurer to submit a claim for overpayment to a provider. Section 641.3155(16), F.S., provides the same requirements for an HMO. All claims for overpayment submitted to a provider licensed under chs. 458 (medical practice), 459 (osteopathic medicine), 460 (chiropractic medicine), 461 (podiatric medicine), or 466 (dentistry), F.S., must be submitted to the provider within 12 months – not 30 months – after the health insurer's or HMO's applicable payment to the provider. A claim for overpayment may not be permitted after 12 months except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234, F.S.

**Agency for Health Care Administration; Health Care Licensing Procedures Act**

As of February 21, 2025, the Agency for Health Care Administration (AHCA) regulates 49,823 health care providers.[13] The Health Care Licensing Procedures Act[14] (Act) provides a streamlined and consistent set of basic licensing requirements for health care providers that are licensed, registered, or certified by the AHCA, including all of the following:[15]

- Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102, F.S.
- Birth centers, as provided under ch. 383, F.S.
- Abortion clinics, as provided under ch. 390, F.S.
- Crisis stabilization units, as provided under parts I and IV of ch. 394, F.S.
- Short-term residential treatment facilities, as provided under parts I and IV of ch. 394, F.S.
- Residential treatment facilities, as provided under part IV of ch. 394, F.S.
- Residential treatment centers for children and adolescents, as provided under part IV of ch. 394, F.S.
- Hospitals, as provided under part I of ch. 395, F.S.

[10] Section 627.6131(6), F.S., and s. 641.3155(5) F.S., for HMO provision.
[11] *Id.*
[12] *Id.*
[13] Agency for Health Care Administration, Senate Bill 786 Legislative Analysis (Feb. 19, 2025) (on file with the Senate Committee on Health Policy).
[14] Chapter 408, Part II, F.S. *See also* s. 408.801(1), F.S.
[15] Section 408.801(2), F.S. The act applies to following providers: 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 developmental disabilities, health care services pools, health care clinics, organ tissue and eye procurement organizations.

- Ambulatory surgical centers, as provided under part I of ch. 395, F.S.
- Nursing homes, as provided under part II of ch. 400, F.S.
- Assisted living facilities, as provided under part I of ch. 429, F.S.
- Home health agencies, as provided under part III of ch. 400, F.S.
- Nurse registries, as provided under part III of ch. 400, F.S.
- Companion services or homemaker services providers, as provided under part III of ch. 400, F.S.
- Adult day care centers, as provided under part III of ch. 429, F.S.
- Hospices, as provided under part IV of ch. 400, F.S.
- Adult family-care homes, as provided under part II of ch. 429, F.S.
- Homes for special services, as provided under part V of ch. 400, F.S.
- Transitional living facilities, as provided under part XI of ch. 400, F.S.
- Prescribed pediatric extended care centers, as provided under part VI of ch. 400, F.S.
- Home medical equipment providers, as provided under part VII of ch. 400, F.S.
- Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of ch. 400, F.S.
- Health care services pools, as provided under part IX of ch. 400, F.S.
- Health care clinics, as provided under part X of ch. 400, F.S.
- Organ, tissue, and eye procurement organizations, as provided under part V of ch. 765, F.S.

The Act is intended to minimize confusion, standardize terminology, and include issues that are not otherwise addressed in state law pertaining to specific providers.[16] Among other things, it provides certain minimum licensure requirements with which applicants and licensees must comply in order to obtain and maintain a license.[17]

**The Department of Health**

The Legislature created the Department of Health (DOH) to protect and promote the health of all residents and visitors in the state.[18] The DOH is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[19] and professions within the DOH.[20] The health care practitioners licensed by the DOH include the following:

- Acupuncturists;[21]
- Allopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants;[22]
- Osteopathic physicians, physician assistants, and anesthesiologist assistants;[23]

[16] Section 408.801(2), F.S.
[17] *See* generally s. 408.810, F.S.
[18] Section 20.43(1), F.S.
[19] Under s. 456.001(1), F.S., "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH MQA.
[20] Section 20.43(3)(g), F.S.
[21] Chapter 457, F.S.
[22] Chapter 458, F.S.
[23] Chapter 459, F.S.

- Chiropractic physicians and physician assistants;[24]
- Podiatric physicians;[25]
- Naturopathic physicians;[26]
- Optometrists;[27]
- Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses, and certified nursing assistants;[28]
- Pharmacists, pharmacy interns, and pharmacy technicians;[29]
- Dentists, dental hygienists, and dental laboratories;[30]
- Midwives;[31]
- Speech and language pathologists;[32]
- Audiologists;[33]
- Occupational therapists and occupational therapy assistants;[34]
- Respiratory therapists;[35]
- Dieticians and nutritionists;[36]
- Athletic trainers;[37]
- Orthotists, prosthetists, and pedorthists;[38]
- Electrologists;[39]
- Massage therapists;[40]
- Clinical laboratory personnel;[41]
- Medical physicists;[42]
- Genetic counselors;[43]
- Opticians;[44]
- Hearing aid specialists;[45]
- Physical therapists;[46]

[24] Chapter 460, F.S.
[25] Chapter 461, F.S.
[26] Chapter 462, F.S.
[27] Chapter 463, F.S.
[28] Chapter 464, F.S.
[29] Chapter 465, F.S.
[30] Chapter 466, F.S.
[31] Chapter 467, F.S.
[32] Part I, ch. 468, F.S.
[33] *Id.*
[34] Part III, ch. 468, F.S.
[35] Part V, ch. 468, F.S.
[36] Part X, ch. 468, F.S.
[37] Part XIII, ch. 468, F.S.
[38] Part XIV, ch. 468, F.S.
[39] Chapter 478, F.S.
[40] Chapter 480, F.S.
[41] Part I, ch. 483, F.S.
[42] Part II, ch. 483, F.S.
[43] Part III, ch. 483, F.S.
[44] Part I, ch. 484, F.S.
[45] Part II, ch. 484, F.S.
[46] Chapter 486, F.S.

- Psychologists and school psychologists;[47] and
- Clinical social workers, mental health counselors, and marriage and family therapists.[48]

**Disciplinary Proceeding under Chapters 456 and 120, F.S.**

Section 456.072, F.S., enumerates at least 45 specific acts that constitute grounds for disciplinary action against licensed health care practitioners in Florida. In addition, each health care practitioner's respective practice act contains specific statutory provisions on prohibited acts, disciplinary actions, grounds for discipline, and actions by the applicable board.

The DOH, on behalf of the boards, investigates any complaint that is filed against a health care practitioner if the complaint is:

- In writing;
- Signed by the complainant;[49] and
- Legally sufficient.[50]

A complaint is legally sufficient if it contains allegations of ultimate facts that, if true, show that a regulated practitioner has violated:

- Chapter 456, F.S.;
- His or her practice act; or
- A rule of his or her board or the DOH.[51]

The Consumer Services Unit, within the DOH, receives the complaints and refers them to the closest Investigative Services Unit (ISU) office. The ISU investigates complaints against health care practitioners.[52] Complaints that present an immediate threat to public safety are given priority; however, all complaints are investigated as timely as possible. When the complaint is assigned to an investigator, the complainant will be contacted and given the opportunity to provide additional information. A thorough investigation will be conducted. The steps taken in the investigation are determined by the specifics of the allegations, but generally include the following:

- Obtaining medical records, documents, and evidence;
- Locating and interviewing the complainant, the patient, the subject, and any witnesses; and
- Drafting and serving subpoenas for necessary information.[53]

[47] Chapter 490, F.S.
[48] Chapter 491, F.S.
[49] Section 456.073(1), F.S. The DOH may also investigate an anonymous complaint, or that of a confidential informant, if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the DOH has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.
[50] *Id.*
[51] *Id.*
[52] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services*, *available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited March 14, 2025).
[53] *Id.*

The ISU includes a staff of professional investigators and senior pharmacists who conduct interviews, collect documents and evidence, prepare investigative reports for the Prosecution Services Unit (PSU), and serve subpoenas and official orders for the DOH.[54]

The PSU is responsible for providing legal services to the DOH in the regulation of all health care boards and councils.[55] The PSU will review the investigative file and report from ISU and recommend a course of action to the State Surgeon General (when an immediate threat to the health, safety, and welfare of the people of Florida exists), the appropriate board's probable cause panel, or the DOH, if there is no board, which may include:

- Having the file reviewed by an expert;
- Issuing a closing order (CO);
- Filing an administrative complaint (AC); or
- Issuing an emergency order (ERO or ESO).[56]

If the ISU investigative file received by the PSU does not pose an immediate threat to the health, safety, and welfare of the people of Florida, then the PSU attorneys review the file and determine, first, whether expert witness review is required and, then, whether to recommend to the board's probable cause panel:

- A CO;
- An AC; or
- A Letter of Guidance (LOG).[57,58]

A CO is recommended if the investigation and/or the expert opinion does not support the allegation(s). The subject and the complainant are notified of the results. The complainant may appeal the decision within sixty (60) days of notification by providing additional information for consideration. Cases closed with no finding of probable cause are confidential and are not available through a public records request.[59]

An AC is recommended when the investigation and/or the expert opinion supports the allegation(s). The subject is entitled to a copy of the complete case file prior to the probable cause panel meeting. When an AC is filed with the agency clerk, at the DOH, the subject has the right to choose one of the following options:

- *An Administrative Hearing Involving Disputed Issues of Material Fact* – The subject disputes the facts in the AC and elects to have a hearing before the Division of Administrative Hearings (DOAH). If this occurs, all parties may be asked to testify and the administrative

[54] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited March 14, 2025).
[55] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Prosecution Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited March 14, 2025).
[56] *Id.*
[57] Section 456.073(2), F.S. The DOH may recommend a LOG in lieu of finding probable cause if the subject has not previously been issued a LOG for a related offense.
[58] *Id.*
[59] *Supra* note 57.

law judge will issue a recommended order that will then go to the board or the DOH for final agency action.

- *A Settlement/Stipulation/Consent Agreement* – The subject enters into an agreement to be presented before the board or the DOH. Terms of this agreement may impose penalties negotiated between the subject or the subject's attorney and the DOH's attorney.
- *A Hearing Not Involving Disputed Issues of Material Fact* – The subject of the AC does not dispute the facts. The subject elects to be heard before the board or the DOH. At that time, the subject will be permitted to give oral and/or written evidence in mitigation or in opposition to the recommended action by the DOH.
- *Voluntary Relinquishment of License* – The subject of the AC may elect to surrender his or her license and to cease practice.[60]

Final DOH action, including all of the above, as well as cases where the subject has failed to respond to an AC, are presented before the applicable board, or the DOH if there is no board. The subject may be required to appear. The complainant is notified of the date and location of the hearing and may attend. If the subject is entitled to, and does, appeal the final decision, PSU defends the final order before the appropriate appellate court.[61]

When the applicable board, or the DOH if there is no board, finds a person guilty, it may enter an order imposing a penalty listed in s. 456.072(2), F.S., which includes revocation, suspension, and restriction of license, administrative fines not to exceed $10,000 per offense, reprimand, probation, corrective action, and remedial education. It must also consider what sanctions are necessary to protect the public or compensate the patient.

## III. Effect of Proposed Changes:

**Section 1** creates s. 408.812, F.S., to require an Agency for Health Care Administration (AHCA) licensee[62] who tenders charges for reimbursement to refund to the patient the amount of any overpayment no later than 30 days after the date that the licensee determines that such overpayment was made. For purposes of this section of statute, the bill defines the term "tenders charges for reimbursement" to mean the licensee files a claim for reimbursement with any government-sponsored program (including Medicaid, Medicare, and Tricare) or private health insurer or health maintenance organization for services rendered to the patient.

The bill's requirement for timely refund of an overpayment would not apply to overpayments made to providers by commercial health insurers subject to s. 627.6131, F.S., or to health maintenance organizations subject to s. 641.3155, F.S.

A licensee's violation of this new section would be subject to an administrative fine under s. 408.813, as amended in section 2 of the bill.

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[60] Chapter 478, F.S.

[61] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services*, *available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited March 14, 2025).

[62] *See* "Agency for Health Care Administration; Health Care Licensing Procedures Act" under "Present Situation" in this Bill Analysis for a list of practitioners who would be required to follow new s. 408.812, F.S.

**Section 2** amends s. 408.813, F.S., to add a violation of s. 408.812, F.S., as created in section 1 of the bill, to a list of unclassified violations,[63] for which the AHCA could impose an administrative fine of up to $500.

**Section 3** creates s. 456.0625, F.S., to require a health care practitioner[64] who tenders charges for reimbursement, or any billing department, management company, or group practice that accepts payment for services rendered by the health care practitioner, to refund the amount of any overpayment made by a patient no later than 30 days after the date that the health care practitioner determines that the overpayment was made. For purposes of this section of statute, the bill defines the term "tenders charges for reimbursement" to mean that the health care practitioner, department, company, or practice files a claim for reimbursement with any government-sponsored program (including Medicaid, Medicare, and Tricare) or private health insurer or health maintenance organization for services rendered to the patient.

The bill's requirement for timely refund of an overpayment would not apply to overpayments made to providers by commercial health insurers subject to s. 627.6131, F.S., or to health maintenance organizations subject to s. 641.3155, F.S.

A violation of s. 456.0625, F.S., would constitute grounds for disciplinary action under the practitioner's practice act and under s. 456.072, F.S., as amended in section 4 of the bill.

**Section 4** amends s. 456.072(1), F.S., to add failure to comply with s. 456.0625, F.S., as created in section 3 of the bill, to the list of grounds for discipline. If the applicable board, or the Department of Health, when there is no board, finds any person guilty of this new ground for discipline, it may discipline the health care practitioner with disciplinary actions specified in s. 456.072(2), F.S.

The bill takes effect January 1, 2026.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[63] An unclassified violation is a violation listed in s. 408.813, F.S., which is not designated as a class I, class II, class III, or class IV violation.
[64] *See* "The Department of Health" under "Present Situation" in this Bill Analysis for a list of practitioners who would be required to follow new s. 456.0625, F.S.

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:

This bill may result in a loss of improper revenue for providers who fail to check for or refund overpayments.

C. Government Sector Impact:

The Department of Health (DOH) reports that the bill may create a workload demand on the department requiring additional staff. Such demand would depend on the volume of complaints filed against health care practitioners under the bill's new requirements. Whether such volume materializes is indeterminant. The DOH estimates the need for two expert witnesses to calculate medical billing overpayments and to provide medical expertise at an annual cost of $83,530.[65]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

The bill creates the following sections of the Florida Statutes: 408.812 and 456.0625.

The bill substantially amends the following sections of the Florida Statutes: 408.13 and 456.072.

[65] Department of Health, Senate Bill 1808 Legislative Analysis (Mar. 14, 2025) (on file with the Senate Committee on Health Policy).

## 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 18, 2025:**
The CS expands the number of parties subject to the bill's 30-day requirement to include the Agency for Health Care Administration (AHCA) licensees, all health care practitioners regulated by the Department of Health (DOH), and anyone who accepts payment from insurance for services rendered by health care practitioners, including billing department, management companies, or group practices. Such parties must refund any overpayment made by the patient no later than 30 days after determining that the patient made an overpayment. The CS defines the term "tenders charges for reimbursement." The CS authorizes the AHCA to impose a fine of up to $500 on a licensee who violates the 30-day refund requirement. The CS also removes a provision in the underlying bill extending rulemaking authority to the DOH.

B. Amendments:

None.

**By** the Committee on Health Policy; and Senator Burton

588-02568-25 20251808c1

A bill to be entitled

An act relating to refund of overpayments made by patients; creating s. 408.12, F.S.; requiring health care facility licensees to refund to the patient any overpayment within a specified timeframe; defining the term "tenders charges for reimbursement"; providing applicability; specifying that health care facility licensees who violate certain provisions are subject to administrative fines; amending s. 408.813, F.S.; revising administrative fines for health care practitioners; amending s. 456.0625, F.S.; requiring health care practitioners to refund to the patient any overpayment within a specified timeframe; defining the term "tenders charges for reimbursement"; providing applicability; specifying that health care practitioners who violate certain provisions are subject to disciplinary actions; amending s. 456.072, F.S.; revising the acts that constitute grounds for disciplinary actions for health care practitioners; providing an effective date.

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

Section 1. Section 408.12, Florida Statutes, is created to read:

408.12 Patient overpayments; refunds.—

(1) A licensee who tenders charges for reimbursement shall refund to the patient the amount of any overpayment made by the patient to the licensee no later than 30 days after the date







588-02568-25 20251808c1

that the licensee determines that such overpayment was made. For purposes of this section, the term "tenders charges for reimbursement" means the licensee files a claim for reimbursement with any government-sponsored program or private health insurer or health maintenance organization for services rendered to the patient.

(2) This section does not apply to an overpayment subject to s. 627.6131 or s. 641.3155.

(3) A licensee who violates this section is subject to an administrative fine under s. 408.813.

Section 2. Paragraph (g) is added to subsection (3) of section 408.813, Florida Statutes, to read:

408.813 Administrative fines; violations.—As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine.

(3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class IV violation. Unless otherwise specified by law, the amount of the fine may not exceed $500 for each violation. Unclassified violations include:

(g) Failing to refund a patient overpayment pursuant to s. 408.12.

Section 3. Section 456.0625, Florida Statutes, is created to read:

456.0625 Patient overpayments; refunds.—

(1) A health care practitioner who tenders charges for reimbursement, or any billing department, management company, or group practice that accepts payment for services rendered by the health care practitioner, shall refund to the patient the amount

of any overpayment made by the patient no later than 30 days after the date that it was determined that an overpayment was made. For purposes of this section, the term "tenders charges for reimbursement" means that the health care practitioner, department, company, or practice files a claim for reimbursement with any government-sponsored program or private health insurer or health maintenance organization for services rendered by the health care practitioner to the patient.

(2) This section does not apply to an overpayment subject to s. 627.6131 or s. 641.3155.

(3) A health care practitioner's violation of this section constitutes grounds for disciplinary action under s. 456.072.

Section 4. Paragraph (tt) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(tt) Failure to comply with s. 456.0625, relating to refunding overpayments to patients.

Section 5. This act shall take effect January 1, 2026.

# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Health Policy, *Chair*
Judiciary, *Vice Chair*
Agriculture
Appropriations Committee on Agriculture, Environment, and General Government
Appropriations Committee on Health and Human Services
Banking and Insurance
Fiscal Policy
Rules

**SENATOR COLLEEN BURTON**
12th District

April 2, 2025

The Honorable Jay Trumbull
415 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Chair Trumball,

I respectfully request SB 1808 Refund of Overpayments Made by Patients be placed on the Appropriations Committee on Health and Human Services agenda at your earliest convenience.

Thank you for your consideration.

Regards,

Colleen Burton

CC: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 1375 Havendale Boulevard, NW, Winter Haven, Florida 33881 (863) 413-1529
❒ 408 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5012

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

**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

**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 Appropriations Committee on Health and Human Services

| | |
|---|---|
| BILL: | CS/CS/SB 1842 |
| INTRODUCER: | Appropriations Committee on Health and Human Services; Health Policy Committee; and Senator Burton |
| SUBJECT: | Out-of-network Providers |
| DATE: | April 14, 2025 REVISED: |

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

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:


CS/CS/SB 1842 requires certain health care practitioners, when referring a patient for nonemergency services, to confirm whether a referral provider participates in the provider network of the patient's health insurer or health maintenance organization (HMO).

The bill requires healthcare practitioners to notify patients in writing when referring them to out-of-network providers that the providers are out of network and that it may result in higher out-of-pocket costs for the patient.

The bill provides that a practitioner who fails to comply without good cause will face disciplinary action and authorizes the Florida Department of Health (DOH) to adopt rules.

The bill has no fiscal impact on state expenditures or revenues. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

## II. Present Situation:

### Insurer

Under s. 627.6471(1)(a), F.S., an "insurer" means:

- Every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity; or
- A multiple-employer welfare arrangement.[1]

### Health Insurance

Under s. 624.603, F.S., "health insurance" is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Health insurance does not include workers' compensation coverages, except as provided in s. 624.406(4), F.S.

### Health Maintenance Organization

Under s. 641.19(12), F.S., a "health maintenance organization" (HMO) is any organization authorized under part I of ch. 641, F.S., which:

- Provides, through arrangements with other persons, emergency care; inpatient hospital services; physician care including care provided by physicians licensed under chs. 458, 459, 460, and 461, F.S.;[2] ambulatory diagnostic treatment; and preventive health care services.
- Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.
- Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers[3] are entitled to receive pursuant to a contract.
- Provides physician services, by physicians licensed under chs. 458, 459, 460, and 461, F.S.,[4] directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.
- If offering services through a managed care system, has a system in which a primary physician licensed under chs. 458, 459, 460, or 461, F.S.,[5] is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the requested

[1] The term "multiple-employer welfare arrangement" means an employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health insurance benefits or any other benefits described in s. 624.33, other than life insurance benefits, to the employees of two or more employers, or to their beneficiaries; *see* s. 624.437(1), F.S.

[2] Chapter 458, F.S., is the practice act for medical doctors, a.k.a. allopathic physicians. Chapter 459, F.S., is the practice act for osteopathic physicians. Chapter 460, F.S., is the practice act for chiropractic physicians. Chapter 461, F.S., is the practice act for podiatric physicians.

[3] "Subscriber" means an entity or individual who has contracted, or on whose behalf a contract has been entered into, with an HMO for health care coverage or other persons who also receive health care coverage as a result of the contract; *see* s. 641.19(18), F.S.

[4] *Supra* note 2.

[5] *Id.*

service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the HMO's provider network.

**Participating vs. Nonparticipating Providers**

Generally, medical health insurance plans and HMOs have a list of physicians, hospitals, and other practitioners or providers[6] that have agreed to participate in the plan's network. Providers participating in the network have a contract with the health plan to care for its members at a certain cost. A member of the plan will typically pay less for medical services when using participating providers. If a plan member sees a practitioner or uses a hospital or other facility that does not participate with the health plan, the member is going out-of-network and will usually have to pay more for services rendered by a nonparticipating provider. Some plans will not cover any amount of out-of-network care, while others cover a percentage of care.[7]

Participating providers[8] have a contract with an insurer that limits the amount of money the provider may charge individuals who are covered under the contracted insurance company. The agreed-upon contract rate includes both the patient and insurer shares and may be based on certain assumptions regarding the volume of patients that will use that provider's services. The portion of the contracted rate a patient pays is determined by his or her insurance policy or HMO subscriber contract.[9]

Nonparticipating providers[10] are those who have not agreed to accept a contracted rate with a patient's insurance company or HMO. If a patient chooses to seek treatment outside of his or her network, insurance companies and HMOs typically increase cost-sharing.[11]

**Health Insurance Cost-Sharing**

The term "cost-sharing" refers to how health plan costs are shared between insurers and insureds, sometimes called "out-of-pocket" costs when referring to the insured's share of costs for services that a plan covers that the insured must pay out of their own pocket.[12]

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[6] "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state; *see* s. 641.47(14), F.S.
[7] Medicare.gov, *Health Maintenance Organizations (HMOs), available at* https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/HMO (last visited Mar. 21, 2025).
[8] "Participating provider" means a preferred provider as defined in s. 627.6471 or an exclusive provider as defined in s. 627.6472; *see* s. 627.64194(1)(f), F.S.
[9] Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know, available at* https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf (last visited Mar. 21, 2025).
[10] "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center defined in s. 395.002 is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate; *see* s. 627.64194(1)(e), F.S.
[11] *Supra* note 9.
[12] *Id.*

***Types of Cost-Sharing***

Health insurance policies and HMO subscriber contracts may include the following types of cost-sharing:

- Premium Contribution – A health coverage premium is the total amount that must be paid in advance to obtain coverage for a particular level of services. Usually, premiums are billed and paid on a monthly basis.[13] Employers typically require employees to share the cost of the plan premium. Employers are free to require employees to cover some or all of the premium cost for dependents, such as a spouse or children.[14]
- Copayments – A copayment or copay is a flat fee paid by the patient at the time of service.[15]
- Coinsurance – Coinsurance is the insured's share of costs of a covered health service, calculated as a percent of the allowed amount for the service. If the plan pays 70 percent of the cost, then the patient pays 30 percent of the cost. If the plan pays 90 percent, then the patient pays 10 percent, and so forth.[16]
- Deductible – The deductible is the amount the insured pays before the plan pays anything. Deductibles generally apply per person per calendar year.[17] Typically, the higher the deductible, the lower the premium. Some plans with particularly high deductibles are known as "high deductible" plans. While these plans may have significantly lower premiums, the insured is usually exposed to higher out-of-pocket costs.[18]
- Out-of-Pocket Maximum – The most that the insured or subscriber could pay during a coverage period (usually one year) for their share of the costs of covered services. After meeting the limit, the plan will usually pay 100 percent of the allowed amount. This limit helps the insured or subscriber plan for health care costs. This limit never includes the premium, balance-billed charges, or health care the plan does not cover. Some plans do not count all copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.[19]

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[13] Centers for Medicare & Medicaid Services, *Course 2 Health Coverage Basics, available at* https://www.cms.gov/marketplace/technical-assistance-resources/training-materials/health-coverage-basics-training.pdf (last visited Mar. 21, 2025).
[14] Kaiser Family Foundation, *Employer-Sponsored Health Insurance 101* (May 28, 2024), *available at* https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-introduction (last visited Mar. 21, 2025).
[15] Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know, available at* https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf (last visited Mar. 21, 2025).
[16] *Id*.
[17] *Id*.
[18] South Carolina Department of Insurance, *Understanding Your Deductible, available at* https://doi.sc.gov/1019/Understanding-Your-Deductible#:~:text=Policies%20with%20lower%20deductibles%20typically,need%20to%20file%20a%20claim. (last visited Mar. 21, 2025).
[19] Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know, available at* https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf (last visited Mar. 21, 2025).

**Regulation of Health Insurance and HMOs in Florida**

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities.[20] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[21] The Florida Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority[22] from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA. As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[23]

***Balance Billing***

A provider, regardless of contracted status with an HMO, may not collect or attempt to collect money from an HMO subscriber.[24] The subscriber is not liable for payment of fees to the provider.[25] Balance billing is also prohibited in cases when emergency services are provided by a nonparticipating provider, and when nonemergency services are provided by a nonparticipating provider and the insured or subscriber does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the covered patient.[26]

**Florida Regulation of Health Care Practitioners**

Health care practitioners[27] are regulated by the Florida Department of Health (DOH) under ch. 456, F.S., and individual practice acts for each profession. Many practitioners are regulated by profession-specific boards or councils of members of the profession appointed by the Governor and administered by the DOH; however, some health care practitioners are regulated directly by the DOH without a board or council.[28]

Chapter 456, F.S., and individual practice acts delineate standards of licensure and practice, and the boards, or the DOH if there is no board, enforce violations under the Administrative Procedure Act. Boards and the DOH may issue a reprimand or letter of concern, assess fines,

[20] Section 20.121(3)(a)1., F.S.
[21] Section 641.21(1), F.S.
[22] Sections 624.401 and 641.49, F.S.
[23] Section 641.495, F.S.
[24] Sections 641.315(1), and 641.3154(1) and (4), F.S.
[25] *Id*.
[26] Section 627.64194, F.S.
[27] "Health care practitioner" means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry, dental hygiene, and dental laboratories); chapter 467 (midwifery); part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics); chapter 478 (electrolysis); chapter 480 (massage therapy practice); part I, part II, or part III of chapter 483 (clinical laboratory personnel, medical physicists, or genetic counseling); chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling, and psychotherapy services); *see* s. 456.001(4), F.S.
[28] Florida Department of Health, *Licensing and Regulation, available at* https://www.floridahealth.gov/licensing-and-regulation/index.html (last visited Mar. 21, 2025).

suspend or restrict licenses, or revoke licenses, among other penalties, based on the nature of the violation.[29]

**Florida Price Transparency: Health Care Facilities**

Under s. 395.301, F.S., a health care facility[30] must provide, within seven days of a written request, a good faith estimate (GFE) of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group[31] or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

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

Current law directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates and that actual charges will be based on the services actually provided.[32]

**Federal Transparency Requirements**

***Federal Transparency in Coverage Requirements – Insurers and HMOs***

On October 29, 2020, the federal departments of Health and Human Services (HHS), Labor, and Treasury finalized Transparency in Coverage regulations[33] imposing new transparency requirements on issuers of individual and group health insurance plans.

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[29] Section 456.072, F.S.
[30] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of ch. 395, F.S.
[31] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention, and resource intensity.
Centers for Medicare & Medicaid Services, *Design and development of the Diagnosis Related Group (DRG)* (Oct. 2020), *available at* https://www.cms.gov/icd10m/version38-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last visited Mar. 21, 2025).
[32] Section 395.301, F.S.
[33] Transparency in Coverage, 85 F.R. 73158 (Nov. 12, 2020) (codified at 29 C.F.R. § 54, 29 C.F.R. § 2590, 45 C.F.R. § 147, and 45 C.F.R. § 158).

Central to the new regulations is a requirement for insurers and HMOs to provide an estimate of an insured's or subscriber's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurers and HMOs must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs before receiving health care services, to encourage shopping and price competition among providers.[34]

***Transparency in Coverage Final Rules***

The Transparency in Coverage Final Rules (TiC Rules) require non-grandfathered group health insurers and HMOs offering non-grandfathered group and individual health insurance coverage to make cost-sharing information available to insureds and subscribers through an Internet-based self-service tool and in paper form, upon request.[35] This information must be made available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the departments[36] in Table 1 of the preamble to the TiC Rules,[37] and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.[38]

The insurer or HMO must make available to an insured or subscriber upon request cost-sharing information for a discrete covered item or service by billing code or descriptive term, and generally must furnish it according to the insured's or subscriber's request.[39] Further, the TiC Rules require an insurer or subscriber to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the insured's or subscriber's request, permitting the individual to specify the information necessary for the insurer or HMO to provide meaningful cost-sharing liability information.[40]

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[34] Health Affairs Blog, *Trump Administration Finalizes Transparency Rule for Health Insurers* (Nov. 1, 2020), *available at* https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last visited Mar. 21, 2025).

[35] 26 C.F.R. § 54.9815-2715A2(b); 29 C.F.R. § 2590.715-2715A2(b); and 45 C.F.R. § 147.211(b). The Consolidated Appropriations Act, 2021 imposed a largely duplicative requirement, and added a requirement that price comparison guidance also be provided by telephone, upon request. *See* also FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), Q3, *available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf, and FAQs about Affordable Care Act Implementation Part 61 (cms.gov) (Sep. 27, 2024) (last visited Mar. 21, 2025).

[36] Department of Treasury, Department of Labor, and Department of Health and Human Services.

[37] 85 F.R. 72158, 72182-90 (Nov. 12, 2020)

[38] 26 C.F.R. § 54.9815-2715A2(c)(1); 29 C.F.R. § 2590.715-2715A2(c)(1); and 45 C.F.R. § 147.211(c)(1).

[39] In responding to an insured's or subscriber's request, the group health plan or health insurer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. 26 C.F.R. § 54.9815-2715A2(b)(2)(ii); 29 C.F.R. § 2590.715-2715A2(b)(2)(ii); and 45 C.F.R. § 147.211(b)(2)(ii).

[40] 26 C.F.R. § 54.9815-2715A2(b)(1); 29 C.F.R. § 2590.715-2715A2(b)(1); and 45 C.F.R. § 147.211(b)(1).

**The Federal "No Surprises" Act**

On December 27, 2020, Congress enacted the No Surprises Act (Act) as part of the Consolidated Appropriations Act of 2021.[41] The Act includes a wide range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of health care. Most sections of the Act went into effect on January 1, 2022, and the federal departments of HHS, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.[42]

***Federal "No Surprises" Act Requirements Relating to Estimates – Facilities***

The Act requires a health insurer or HMO to generate an "advanced explanation of benefits" (AEOB) that combines information on charges provided by a hospital facility with patient-specific cost information provided by a policy or contract. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a GFE of the total expected charges for scheduled items or services, including any expected ancillary services, with a health insurer (if the patient is insured) or individual (if the patient is uninsured).[43]

***Federal "No Surprises" Act Requirements of Health Insurers and HMOs***

Under the Act, once the GFE has been shared with a patient's health insurer or HMO, then the insurer or HMO must then develop the AEOB. This personalized cost estimate must include the following:[44]

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

***Deferral of Federal Enforcement Related to the GFEs and the AEOBs for Insured Individuals***

In October 2021, the decision to defer enforcement of certain requirements described above was made in response to stakeholder requests that standards first be established for the data transfer from providers and facilities to plans and issuers, and give plans, issuers, providers, and facilities enough time to build the infrastructure necessary to support the transfers.

[41] Public Law 116-260. The No Surprises Act is found in Division BB of the Act.
[42] Public Law 116-260. The No Surprises Act is found in Division BB of the Act.
[43] *Id*.
[44] *Id*.

In September 2022, the federal government issued a Request for Information (RFI) relating to the AEOB and the GFE for covered individuals. In the RFI, as noticed in the Federal Register, it was stated that the HHS is deferring enforcement of the requirement that providers and facilities must provide a GFE to plans and issuers for covered individuals enrolled in a health plan or coverage and seeking to have a claim submitted for scheduled (or requested) items or services to their plan or coverage, as well as deferring enforcement of the requirement that plans and issuers must provide these covered individuals with an AEOB.[45]

On April 23, 2024, the federal government provided an update[46] on progress towards AEOB rulemaking and implementation. The update included a summary of comments received in response to the September 2022 RFI. According to the update, various types of health care providers, payers, and third-party vendors were studied to understand technical needs and capabilities, existing claims processes, communications channels, and potential financial and operational constraints. Additionally, the federal government engaged digital service researchers, who recommended a single data exchange standard for the transmission of data between payers and providers and emphasized that current published technical standards may not be sufficient to meet the AEOB requirements. As a result, new standards may need to be developed to ensure successful implementation.[47]

At this time, no further federal guidance has been issued to indicate how long enforcement will be deferred.[48]

## III. Effect of Proposed Changes:

**Section 1** amends s. 456.0575, F.S., to require a health care practitioner providing nonemergency services, as defined in s. 627.64194, F.S., to a patient and referring the patient to a provider for nonemergency services, to confirm whether the referral provider participates in the provider network of the patient's health insurer or Health Maintenance Organization (HMO) at the point of service. The practitioner, or his or her employee, may confirm the referral provider's participation by contacting the referral provider or the patient's health insurer or HMO, as necessary, or may rely on the online provider directory of the health insurer or HMO.

The bill provides that such requirement does not apply if the patient declines in writing the offer to confirm whether other providers participate in the patient's health insurer or HMO provider network.

The bill requires that when making a referral, a practitioner must notify a patient in writing that services provided by an out-of-network provider or that are not covered services under the

[45] 87 F.R. 56905.
[46] Centers for Medicare & Medicaid Services, *Progress Toward Advanced Explanation of Benefits (AEOB) Rulemaking and Implementation, available at* https://www.cms.gov/files/document/progress-aeob-rulemaking-implementation.pdf (last visited Mar. 22, 2025).
[47] NFP, An Aon Company, *FAQ: When must group health plans comply with the CAA 2021 Advanced Explanation of Benefits (AEOB) requirement, available at* https://www.nfp.com/insights/faq-when-must-group-health-plans-comply-with-the-caa-2021-advanced-explanation-of-benefits-aeob-requirement/ (last visited Mar. 22, 2025).
[48] *Id*.

patient's health coverage may result in additional cost-sharing responsibilities for the patient, and such notice must be documented in the patient's medical record. Failure to comply, without good cause, will result in disciplinary action against the health care practitioner.

The bill authorizes the Department of Health (DOH) to adopt rules to implement its provisions.

The bill takes effect 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:

The bill may result in an indeterminate negative fiscal impact on healthcare practitioners who may see an increased workload due to the provisions in the bill.

C. Government Sector Impact:

The bill has no fiscal impact on state expenditures or revenues.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

Section 1 requires that disciplinary action be taken against a health care practitioner who fails to comply, without good cause, with the bill's requirement for written patient notifications. However, it is unclear what constitutes "good cause" or a "disciplinary action."

## VIII. Statutes Affected:

This bill substantially amends section 456.0575 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/CS by Appropriations Committee on Health and Human Services on April 10, 2025:**

The committee substitute:

- Requires a patient to notify a practitioner *in writing* if they do not wish for confirmation that a referral provider participates in the provider network of the patient's health insurer or health maintenance organization (HMO).
- Allows practitioners to confirm whether the referral provider participates in the provider network of the patient's health insurer or HMO by relying on the online provider directory of the health insurer or HMO.

**CS by Health Policy on March 25, 2025:**

The committee substitute:

- Removes the underlying bill's amendments to the Insurance Code relating to health insurance deductibles.
- Clarifies that a health care practitioner providing nonemergency services to a patient and making a referral to another provider for nonemergency services, must confirm the referral provider's participation in the provider network of the patient's health insurer or Health Maintenance Organization (HMO) at the point of service unless the patient declines the practitioner's offer to make the network confirmation or declines to share identifying information with the referral provider. The CS allows the referring practitioner to delegate this duty to an employee.
- Requires a practitioner to notify a patient in writing when additional cost-sharing responsibilities are possible when making a referral for services provided by an out-of-network provider or that are not covered services under the patient's health coverage.
- Authorizes the Department of Health (DOH) to adopt rules.

### B. Amendments:

None.

416222

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 04/10/2025 | . | |
| | . | |
| | . | |
| | . | |

The Appropriations Committee on Health and Human Services (Burton) recommended the following:

**Senate Amendment**

Delete lines 34 - 39
and insert:
maintenance organization, as necessary, or may rely on the online provider directory of the health insurer or health maintenance organization.

(b) The requirements of paragraph (a) do not apply if the patient indicates in writing that he or she does not wish the referring health care practitioner to confirm whether other


providers participate in the provider network of the patient's health insurer or health maintenance organization.

**By** the Committee on Health Policy; and Senator Burton

588-02850-25 20251842c1

A bill to be entitled

An act relating to out-of-network providers; amending s. 456.0575, F.S.; requiring a health care practitioner or his or her employee to confirm whether a referral provider participates in the provider network of the patient's health insurer or health maintenance organization under certain circumstances; authorizing the practitioner or his or her employee to confirm the referral provider's participation in a specified manner; providing applicability; requiring a health care practitioner to notify a patient in writing that certain services are not covered services under the patient's health coverage; requiring that such notice be documented; providing for health care practitioner disciplinary action under certain conditions; authorizing the Department of Health to adopt rules; providing an effective date.

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

Section 1. Present subsection (2) of section 456.0575, Florida Statutes, is redesignated as subsection (3), and a new subsection (2) is added to that section, to read:

456.0575 Duty to notify patients.—

(2)(a) When providing nonemergency services, as defined in s. 627.64194, to a patient, and referring the patient to a provider for nonemergency services, a health care practitioner or his or her employee must, at the point of service, confirm whether the referral provider participates in the provider network of the patient's health insurer or health maintenance organization. The practitioner or his or her employee may confirm the referral provider's participation by contacting the referral provider or the patient's health insurer or health maintenance organization, as necessary.

(b) The requirements of paragraph (a) do not apply if the patient declines the practitioner's offer to make the confirmation or declines to share with the referral provider the name and identification number associated with his or her health insurance policy or health maintenance organization contract.

(c) When making any referral, the practitioner must notify a patient in writing that services provided by an out-of-network provider or that are not covered services under the patient's health coverage may result in additional cost-sharing responsibilities for the patient, and such notice must be documented in the patient's medical record.

(d) Failure to comply with this subsection, without good cause, shall result in disciplinary action against the health care practitioner.

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

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

# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Health Policy, *Chair*
Judiciary, *Vice Chair*
Agriculture
Appropriations Committee on Agriculture, Environment, and General Government
Appropriations Committee on Health and Human Services
Banking and Insurance
Fiscal Policy
Rules

**SENATOR COLLEEN BURTON**
12th District

March 26, 2025

The Honorable Jay Trumbull
415 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Chair Trumball,

I respectfully request SB 1842 Out-of-network Providers be placed on the Appropriations Committee on Health and Human Services agenda at your earliest convenience.

Thank you for your consideration.

Regards,

Colleen Burton

CC: Brooke McKnight, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 1375 Havendale Boulevard, NW, Winter Haven, Florida 33881 (863) 413-1529
❒ 408 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5012

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

**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Appropriations Committee on Health and Human Services, *Vice Chair*
Appropriations Committee on Higher Education
Commerce and Tourism
Education Pre-K - 12
Fiscal Policy
Health Policy
Transportation

**JOINT COMMITTEE:**
Joint Legislative Auditing Committee

**SENATOR TRACIE DAVIS**
*Democratic Leader Pro Tempore*
5th District

April 9, 2025

The Honorable Jay Trumbull
Appropriations Committee on Health and Human Services, Chair
201 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Harrell,

I respectfully request an excused absence from the April 10, 2025, Appropriations Committee on Health and Human Services committee meeting.

Thank you for your consideration.

Sincerely,

Tracie Davis
State Senator
District 05

❒ 2933 North Myrtle Avenue, Suite 201, Jacksonville, Florida 32209 (904) 359-2575
❒ 210 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5005

# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Appropriations Committee on Criminal and Civil Justice, *Chair*
Children, Families, and Elder Affairs, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Criminal Justice
Ethics and Elections
Rules

**SENATOR ILEANA GARCIA**
36th District

April 10, 2025

**The Honorable Jay Trumbull**
Chair, Appropriations Committee on Health and Human Services.
201 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Trumbull,

Senator Garcia respectfully requests an excused absence from the April 10th, 2025, Appropriations Committee on Health and Human Services meeting.

I appreciate your consideration.

Sincerely,

Angelo Remuzgo
Legislative Aide to Senator Ileana Garcia

REPLY TO:
❒ 2828 Coral Way, Suite 208, Miami, Florida 33145 (305) 442-6841
❒ 314 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5036

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

**BEN ALBRITTON**
**President of the Senate**

**JASON BRODEUR**
**President Pro Tempore**

# CourtSmart Tag Report

**Room:** KB 412 **Case No.:** - **Type:**
**Caption:** Appropriations Committee on Health and Human Services **Judge:**

**Started: 4/10/2025 8:35:21 AM**
**Ends: 4/10/2025 10:13:09 AM Length: 01:37:49**

**8:35:24 AM** Sen. Trumbull (Chair)
**8:36:21 AM** S 976
**8:36:27 AM** Sen. Bernard
**8:37:22 AM** Sen. Trumbull
**8:37:29 AM** Sen. Bernard
**8:37:31 AM** Sen. Trumbull
**8:37:56 AM** S 306
**8:38:02 AM** Sen. Sharief
**8:39:04 AM** Sen. Trumbull
**8:39:12 AM** Sen. Sharief
**8:39:15 AM** Sen. Trumbull
**8:39:39 AM** S 584
**8:39:47 AM** Sen. Brodeur
**8:40:20 AM** Sen. Trumbull
**8:40:32 AM** Austin Lawson, Florida Youth Shine
**8:41:43 AM** Qua'viona Peeples, Florida Youth Shine
**8:43:32 AM** Noah Corcoran, Lobbyist, Florida Youth Shine (waives in support)
**8:43:37 AM** Sen. Trumbull
**8:43:41 AM** Sen. Berman
**8:44:08 AM** Sen. Trumbull
**8:44:13 AM** Sen. Brodeur
**8:44:39 AM** Sen. Trumbull
**8:45:03 AM** S 1412
**8:45:06 AM** Sen. Calatayud
**8:45:33 AM** Sen. Trumbull
**8:45:36 AM** Denise Bellville, Lobbyist, Home Care Association of Florida (waives in support)
**8:45:45 AM** Sen. Trumbull
**8:45:50 AM** Sen. Calatayud
**8:45:52 AM** Sen. Trumbull
**8:46:20 AM** S 1800
**8:46:23 AM** Sen. Calatayud
**8:46:48 AM** Sen. Trumbull
**8:46:54 AM** Am. 121756
**8:46:57 AM** Sen. Calatayud
**8:47:09 AM** Sen. Trumbull
**8:47:17 AM** Sen. Calatayud
**8:47:19 AM** Sen. Trumbull
**8:47:20 AM** S 1800 (cont.)
**8:47:25 AM** Sen. Berman
**8:47:35 AM** Sen. Calatayud
**8:47:53 AM** Sen. Trumbull
**8:48:01 AM** Gus Corbella, Lobbyist, Michael J. Fox Foundation For Parkinson's Research (waives in support)
**8:48:08 AM** Donald Mullins, USF Morsani College of Medicine (waives in support)
**8:48:14 AM** Sen. Trumbull
**8:48:19 AM** Sen. Berman
**8:48:40 AM** Sen. Trumbull
**8:48:42 AM** Sen. Harrell
**8:49:52 AM** Sen. Trumbull
**8:49:56 AM** Sen. Calatayud
**8:50:02 AM** Sen. Trumbull
**8:50:26 AM** S 1270
**8:50:33 AM** Sen. Collins

**8:52:23 AM** Sen. Trumbull
**8:52:26 AM** Am. 120352
**8:52:27 AM** Sen. Collins
**8:53:08 AM** Sen. Trumbull
**8:53:13 AM** Sen. Brodeur
**8:53:38 AM** Sen. Collins
**8:53:44 AM** Sen. Trumbull
**8:53:48 AM** Sen. Berman
**8:54:05 AM** Sen. Collins
**8:54:39 AM** Sen. Berman
**8:55:01 AM** Sen. Collins
**8:55:15 AM** Sen. Trumbull
**8:55:22 AM** Sen. Collins
**8:55:26 AM** Sen. Trumbull
**8:55:34 AM** S 1270 (cont.)
**8:55:40 AM** Sen. Berman
**8:55:59 AM** Sen. Collins
**8:56:26 AM** Sen. Trumbull
**8:56:29 AM** Sen. Harrell
**8:57:20 AM** Sen. Collins
**8:57:50 AM** Sen. Harrell
**8:58:09 AM** Sen. Collins
**8:58:42 AM** Sen. Trumbull
**8:58:51 AM** Sen. Berman
**8:59:18 AM** Sen. Trumbull
**8:59:20 AM** Sen. Gruters
**8:59:30 AM** Sen. Trumbull
**8:59:32 AM** Sen. Harrell
**8:59:58 AM** Sen. Trumbull
**9:00:00 AM** Sen. Collins
**9:00:44 AM** Sen. Trumbull
**9:01:28 AM** S 524
**9:01:33 AM** Sen. Harrell
**9:02:59 AM** Sen. Trumbull
**9:03:01 AM** Am. 342978
**9:03:08 AM** Sen. Harrell
**9:03:15 AM** Sen. Trumbull
**9:03:18 AM** Sen. Berman
**9:03:33 AM** Sen. Harrell
**9:03:43 AM** Sen. Trumbull
**9:03:52 AM** Sen. Harrell
**9:03:53 AM** Sen. Trumbull
**9:03:57 AM** S 524 (cont.)
**9:04:01 AM** Katie Flury, Lobbyist, Nemours (waives in support)
**9:04:08 AM** Sen. Trumbull
**9:04:13 AM** Sen. Harrell
**9:04:27 AM** Sen. Trumbull
**9:04:54 AM** S 1156
**9:05:02 AM** Sen. Harrell
**9:07:44 AM** Sen. Trumbull
**9:07:50 AM** Tonya Jackson, Lobbyist (waives in support)
**9:07:55 AM** Denise Bellville, Lobbyist, Home Care Association of Florida (waives in support)
**9:08:04 AM** Sen. Trumbull
**9:08:07 AM** Sen. Harrell
**9:08:27 AM** Sen. Trumbull
**9:08:53 AM** S 1490
**9:09:00 AM** Sen. Harrell
**9:12:01 AM** Sen. Trumbull
**9:12:04 AM** Am. 649872
**9:12:17 AM** Sen. Harrell
**9:12:23 AM** Sen. Trumbull
**9:12:33 AM** Sen. Harrell

**9:12:34 AM** Sen. Trumbull
**9:12:35 AM** Sen. Harrell
**9:12:39 AM** Sen. Trumbull
**9:12:44 AM** S 1490 (cont.)
**9:12:50 AM** Sen. Berman
**9:13:02 AM** Sen. Harrell
**9:13:22 AM** Sen. Trumbull
**9:13:26 AM** Brian Myer, Deputy Secretary of Medicaid, Agency for Health Care Administration (waives in support)
**9:13:32 AM** Sen. Trumbull
**9:13:38 AM** Sen. Harrell
**9:13:56 AM** Sen. Trumbull
**9:14:29 AM** S 1174
**9:14:40 AM** Sen. Rouson
**9:15:18 AM** Sen. Trumbull
**9:15:23 AM** Am. 166904
**9:15:29 AM** Sen. Rouson
**9:15:33 AM** Sen. Trumbull
**9:15:38 AM** S 1174 (cont.)
**9:15:45 AM** Sen. Rouson
**9:15:47 AM** Sen. Trumbull
**9:16:14 AM** S 1620
**9:16:17 AM** Sen. Rouson
**9:18:24 AM** Sen. Trumbull
**9:18:30 AM** Natalie Kelly, Lobbyist, Florida Association of Managing Entities (waives in support)
**9:18:35 AM** Lauren Hartmann, Lobbyist, University of South Florida (waives in support)
**9:18:37 AM** Sen. Trumbull
**9:18:39 AM** Sen. Berman
**9:19:19 AM** Sen. Trumbull
**9:19:22 AM** Sen. Harrell
**9:20:41 AM** Sen. Trumbull
**9:20:45 AM** Sen. Rouson
**9:20:47 AM** Sen. Trumbull
**9:21:24 AM** S 1568
**9:21:28 AM** Sen. Brodeur
**9:21:59 AM** Sen. Trumbull
**9:22:01 AM** Am. 584482
**9:22:02 AM** Am. 909488
**9:23:25 AM** Sen. Brodeur
**9:24:06 AM** Sen. Trumbull
**9:24:26 AM** Paul Ledford, Lobbyist, Florida Hospice and Palliative Care Association (waives in support)
**9:24:33 AM** Sen. Trumbull
**9:24:38 AM** Sen. Brodeur
**9:24:50 AM** Sen. Trumbull
**9:25:00 AM** S 1568 (cont.)
**9:25:10 AM** Sen. Harrell
**9:25:34 AM** Sen. Brodeur
**9:25:37 AM** Sen. Trumbull
**9:25:51 AM** Paul Ledford, Lobbyist, Florida Hospice and Palliative Care Association (waives in support)
**9:25:53 AM** Sen. Trumbull
**9:26:03 AM** Sen. Harrell
**9:26:18 AM** Sen. Trumbull
**9:26:19 AM** Sen. Brodeur
**9:26:22 AM** Sen. Trumbull
**9:26:50 AM** S 788
**9:26:53 AM** Sen. Truenow
**9:27:40 AM** Sen. Trumbull
**9:27:47 AM** Bob Asztalos, Lobbyist, Florida Department of Veterans' Affairs (waives in support)
**9:27:50 AM** Tom Parker, Lobbyist, Florida Health Care Association (waives in support)
**9:27:53 AM** Sen. Trumbull
**9:27:56 AM** Sen. Truenow
**9:28:14 AM** Sen. Trumbull
**9:28:36 AM** S 1606

**9:28:47 AM** Sen. Bradley
**9:29:34 AM** Sen. Trumbull
**9:29:40 AM** Dr. David Bellamy
**9:34:19 AM** Cynthia Henderson, Lobbyist
**9:37:13 AM** Elizabeth McElhiney
**9:40:31 AM** Sen. Trumbull
**9:40:40 AM** Sen. Harrell
**9:41:42 AM** Sen. Trumbull
**9:41:47 AM** Sen. Bradley
**9:43:04 AM** Sen. Trumbull
**9:44:10 AM** S 1736
**9:44:14 AM** Sen. Bradley
**9:45:28 AM** Sen. Trumbull
**9:45:32 AM** Am. 574242
**9:45:36 AM** Sen. Bradley
**9:45:50 AM** Sen. Trumbull
**9:45:57 AM** Sen. Bradley
**9:45:58 AM** Sen. Trumbull
**9:46:01 AM** S 1736 (cont.)
**9:46:06 AM** Dina Justice, Lobbyist, The Arc of Florida (waives in support)
**9:46:12 AM** Sen. Trumbull
**9:46:14 AM** Sen. Bradley
**9:46:18 AM** Sen. Trumbull
**9:46:48 AM** S 1808
**9:47:06 AM** Sen. Burton
**9:47:55 AM** Sen. Trumbull
**9:48:07 AM** Sen. Burton
**9:48:09 AM** Sen. Trumbull
**9:48:34 AM** S 1842
**9:48:39 AM** Sen. Burton
**9:49:20 AM** Sen. Trumbull
**9:49:22 AM** Am. 416222
**9:49:29 AM** Sen. Burton
**9:50:05 AM** Sen. Trumbull
**9:50:17 AM** Sen. Burton
**9:50:18 AM** Sen Trumbull
**9:50:21 AM** S 1842 (cont.)
**9:50:25 AM** Sen. Berman
**9:50:46 AM** Sen. Burton
**9:51:02 AM** Sen. Trumbull
**9:51:11 AM** Sen. Harrell
**9:51:51 AM** Sen. Trumbull
**9:51:57 AM** Sen. Burton
**9:52:45 AM** Sen. Trumbull
**9:53:19 AM** Sen. Brodeur (Chair)
**9:53:24 AM** S 1354
**9:53:31 AM** Sen. Trumbull
**9:54:46 AM** Sen. Brodeur
**9:54:52 AM** Sen. Rouson
**9:55:16 AM** Sen. Trumbull
**9:55:50 AM** Sen. Brodeur
**9:56:01 AM** Sen. Rouson
**9:57:05 AM** Sen. Brodeur
**9:57:10 AM** Sen. Berman
**9:57:47 AM** Sen. Brodeur
**9:57:50 AM** Sen. Trumbull
**9:58:03 AM** Sen. Brodeur
**9:58:28 AM** S 1768
**9:58:31 AM** Sen. Trumbull
**9:59:16 AM** Sen. Brodeur
**9:59:21 AM** Sen. Harrell
**9:59:45 AM** Sen. Trumbull

**9:59:53 AM** Sen. Brodeur
**9:59:57 AM** Sen. Berman
**10:00:22 AM** Sen. Trumbull
**10:01:04 AM** Sen. Berman
**10:01:15 AM** Sen. Trumbull
**10:01:34 AM** Sen. Berman
**10:01:46 AM** Sen. Brodeur
**10:01:55 AM** Sen. Berman
**10:03:19 AM** Sen. Brodeur
**10:03:23 AM** Sen. Harrell
**10:04:35 AM** Sen. Brodeur
**10:05:32 AM** Sen. Trumbull
**10:06:04 AM** Sen. Brodeur
**10:06:36 AM** S 7032
**10:06:43 AM** Sen. Trumbull
**10:09:15 AM** Sen. Brodeur
**10:09:17 AM** Dina Justice, Lobbyist, The Arc of Florida (waives in support)
**10:09:22 AM** Sen. Brodeur
**10:09:28 AM** Sen. Harrell
**10:10:09 AM** Sen. Brodeur
**10:10:13 AM** Sen. Trumbull
**10:10:47 AM** Sen. Brodeur
**10:11:20 AM** Sen. Trumbull
**10:11:29 AM** S 1606
**10:11:32 AM** Sen. Brodeur
**10:12:15 AM** Sen. Trumbull (Chair)
**10:12:32 AM** Sen. Rodriguez
**10:12:39 AM** Sen. Trumbull
**10:12:41 AM** Sen. Gruters
**10:12:45 AM** Sen. Trumbull
**10:12:48 AM** Sen. Burton
**10:12:54 AM** Sen. Trumbull