Tab 1	**SB 36** by **Sharief (CO-INTRODUCERS) Osgood, Davis, Rouson, Berman;** Similar to CS/H 00237 Use of Professional Nursing Titles					
690594	A	S	RCS	HP, Sharief	Delete L.16 - 24:	02/03 01:15 PM

Tab 2	**SB 864** by **Sharief;** Identical to H 01515 Public Records/Uterine Fibroid Research Database					
338936	A	S	RCS	HP, Sharief	Delete L.45 - 48:	02/03 01:15 PM

Tab 3	**SB 268** by **Rodriguez (CO-INTRODUCERS) Harrell;** Similar to H 00251 Public Records/Emergency Physicians					
519420	D	S	RCS	HP, Rodriguez	Delete everything after	02/03 01:15 PM

Tab 4	**SB 844** by **Jones;** Identical to H 00353 Sickle Cell Disease Care Management and Treatment Continuing Education

Tab 5	**SB 514** by **Osgood;** Identical to H 00515 Doula Support for Healthy Births Pilot Program					
199948	A	S	RCS	HP, Osgood	Delete L.134 - 206:	02/03 01:15 PM

Tab 6	**SB 1404** by **Burton;** Similar to H 01295 Memory Care					
537686	D	S	RCS	HP, Burton	Delete everything after	02/03 01:15 PM

Tab 7	**SB 914** by **Calatayud;** Similar to H 00867 Dry Needling					
507366	A	S	RCS	HP, Calatayud	Delete L.41 - 80:	02/03 01:15 PM

Tab 8	**SB 1758** by **Gaetz (CO-INTRODUCERS) Brodeur;** Compare to H 00693 Public Assistance					
654120	A	S	RS	HP, Gaetz	Delete L.435 - 436:	02/03 01:15 PM
498120	SA	S	RCS	HP, Gaetz	Delete L.435 - 436:	02/03 01:15 PM
838908	A	S	RCS	HP, Gaetz	Delete L.457 - 461:	02/03 01:15 PM
822634	A	S	RCS	HP, Gaetz	Delete L.602:	02/03 01:15 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Harrell, Vice Chair

MEETING DATE: Monday, February 2, 2026
TIME: 3:30—5:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 36** Sharief (Similar CS/H 237)	Use of Professional Nursing Titles; Authorizing persons who hold specified licenses to practice professional nursing or to perform nursing services to use certain titles and abbreviations; requiring doctoral degree holders to specify their profession when using a specified title, etc. HP 02/02/2026 Fav/CS AHS RC	Fav/CS Yeas 9 Nays 2
2	**SB 864** Sharief (Identical H 1515, Compare H 327, Linked S 196)	Public Records/Uterine Fibroid Research Database; Providing an exemption from public records requirements for certain records and personal identifying information submitted to the Department of Health for inclusion in the uterine fibroid research database; providing for future legislative review and repeal; providing a statement of public necessity, etc. HP 02/02/2026 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 1
3	**SB 268** Rodriguez (Similar H 251)	Public Records/Emergency Physicians; Defining the term “emergency physician”; providing exemptions from public records requirements for the personal identifying and location information of current or former emergency physicians and the spouses and children of such emergency physicians; providing for future legislative review and repeal of the exemption; providing a statement of public necessity, etc. HP 02/02/2026 Fav/CS GO RC	Fav/CS Yeas 11 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 844** Jones (Identical H 353)	Sickle Cell Disease Care Management and Treatment Continuing Education; Revising requirements for a continuing education course on prescribing controlled substances which health care practitioners are required to complete; requiring the applicable licensing boards for specified health care professions to require a 2-hour continuing education course on sickle cell disease care management as part of the first licensure or certification renewal; specifying requirements for the course; authorizing the applicable boards to approve additional equivalent courses to satisfy the requirement, etc. HP 02/02/2026 Favorable AHS FP	Favorable Yeas 11 Nays 0
5	**SB 514** Osgood (Identical H 515)	Doula Support for Healthy Births Pilot Program; Establishing the pilot program in Broward, Miami-Dade, and Palm Beach Counties for a specified purpose; requiring the Department of Health, in collaboration with its maternal and child health section, to implement and oversee the pilot program; requiring the department to collaborate with specified entities to integrate doula services into existing maternal health programs and facilitate outreach and service delivery; creating the Doula Certification Task Force within the department for a specified purpose, etc. HP 02/02/2026 Fav/CS AHS FP	Fav/CS Yeas 11 Nays 0
6	**SB 1404** Burton (Similar H 1295, Compare CS/S 1630)	Memory Care; Defining the term “memory care services”; requiring facilities claiming to provide memory care services to meet specified standards of operation in providing such services; repealing a provision relating to special care for persons with Alzheimer’s disease or other related disorders; providing the purpose of the Florida Alzheimer’s Center of Excellence; defining terms; creating the center within the Department of Elderly Affairs, etc. HP 02/02/2026 Fav/CS AHS FP	Fav/CS Yeas 11 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 914** Calatayud (Similar H 867)	Dry Needling; Defining the terms “dry needling” and “myofascial trigger point”; requiring the Board of Occupational Therapy to establish minimum standards of practice for the performance of dry needling by occupational therapists, including specified standards; requiring the board, if it deems it necessary for patient safety, to adopt additional supervision and training requirements for occupational therapists to perform dry needling on specified areas, etc. HP 02/02/2026 Fav/CS AHS RC	Fav/CS Yeas 11 Nays 0
8	**SB 1758** Gaetz (Compare H 693, H 1453)	Public Assistance; Authorizing the Agency for Health Care Administration to conduct retrospective reviews and audits of certain claims under the state Medicaid program for a specified purpose; requiring the agency to seek federal approval to implement mandatory work and community engagement requirements for able-bodied adults as a condition of obtaining and maintaining Medicaid coverage; requiring the agency, in consultation with the Department of Children and Families, to develop a business plan to implement specified provisions; revising the purpose of the Medicaid Pharmaceutical and Therapeutics Committee to include creation of a Medicaid preferred physician-administered drug list, a Medicaid preferred product list, and a high-cost drug list; requiring the department to develop and implement a food assistance payment accuracy improvement plan for a specified purpose, etc. HP 02/02/2026 Fav/CS AP	Fav/CS Yeas 8 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 Committee on Health Policy

BILL:	CS/SB 36
INTRODUCER:	Health Policy Committee and Senator Sharief and others
SUBJECT:	Use of Professional Nursing Titles
DATE:	February 3, 2026
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 36 explicitly authorizes licensed nurses to use the titles "Doctor of Nursing Practice" or "Doctor of Philosophy" and the corresponding abbreviations, "D.N.P." or "Ph.D.," if the nurse holds that doctoral degree. The bill prohibits a nurse who holds a doctoral degree from using the title "doctor" in a clinical setting without clearly specifying his or her profession.

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

II. Present Situation:

Nurse Licensure and Regulation

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over Florida's licensed health care practitioners. The MQA works in conjunction with the Board of Nursing (Board), created under part I of ch. 464, F.S., to license and regulate approximately 50,378 advanced practice registered nurses (APRNs), 62,230 licensed practical nurses (LPNs), and 347,857 registered nurses (RNs) who are practicing in Florida under an active Florida license.[1] The DOH and the Board also regulate approximately

[1] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2024-25*, at 10, available at https://mqawebteam.com/annualreports/2425/2/ (last visited Jan. 28, 2025).

4,195 RNs and 549 LPNs from other states who are authorized to practice in Florida through the Nurse Licensure Compact.[2]

To become initially licensed as an LPN or RN in Florida, an applicant must have completed an accredited or Board-approved pre-licensure nursing education program and passed the National Council of State Boards of Nursing Licensure Examination (NCLEX).[3] Nurses licensed in other states may apply for licensure by endorsement under the MOBILE Act.[4] Additionally, Florida is a member of the Nurse Licensure Compact which enables RNs and LPNs licensed to practice in other compact states to be able to practice in Florida if they have been issued a multistate license under the compact.[5]

Within the nursing profession, there are two primary categories of licensure: practical nurses and professional nurses. The Nurse Practice Act, codified within part I of ch. 464, F.S., distinguishes between the practice of practical nursing and the practice of professional nursing.

Practical nursing consists of performing selected nursing acts, such as administering treatments and medications, under the direction of a registered nurse, physician, or certain other licensed health care providers. It focuses on the care of individuals who are ill or infirm, and on promoting wellness and preventing illness.[6]

Professional nursing involves the performance of acts that require substantial, specialized knowledge, judgment, and skill based on scientific principles from the psychological, biological, physical, and social sciences. This includes comprehensive responsibilities such as assessing and diagnosing patient needs, planning and evaluating care, administering treatments and medications under proper authorization, and supervising or teaching others in the performance of these duties.[7]

The licensed practical nurses (LPNs) are licensed to practice practical nursing under supervision whereas the registered (professional) nurses (RNs) are licensed to practice professional nursing. The RNs who complete additional graduate- or doctoral-level education may obtain licensure as an advanced practice registered nurse (APRN). In Florida, The APRNs are licensed in one or more of the following roles: nurse practitioner (NP), certified nurse midwife (CNM), clinical nurse specialist (CNS), psychiatric-mental health nurse practitioner, and certified registered nurse anesthetist (CRNA).[8]

The APRNs seeking to register to practice primary care autonomously, or for CNMs seeking to register to practice midwifery autonomously, i.e. without physician supervision, must complete 3,000 clinical practice hours, which may include clinical instruction provided by faculty in a

[2] *Id*. at 31.
[3] Section 464.008, F.S.
[4] Section 456.0145, F.S.
[5] Section 464.0095, F.S. *See also* National Council of State Boards of Nursing, *Participating Jurisdictions*, available at https://www.nursecompact.com/index.page#map (last visited Jan. 28, 2026).
[6] Section 464.003(18), F.S.
[7] Section 464.003(19), F.S.
[8] Section 464.003(3), F.S.

clinical setting in a graduate program leading to a master's or doctoral degree in a clinical nursing specialty area.[9]

Post-licensure Nursing Programs

A post-licensure nursing program is a nursing education program designed for people who are already licensed as nurses, most commonly RNs, who want to build upon their existing clinical foundation to advance their education, role, or specialty. Common programs include:

- Registered Nurse to Bachelor of Science in Nursing (RN to BSN);
- Master of Science in Nursing (MSN);
- Doctor of Nursing Practice (DNP);
- Doctor of Philosophy (Ph.D.); and
- Specialty nursing certificates.

The Florida Center for Nursing reported that in 2023, 11.9 percent of Florida APRNs and 1.1 percent of RNs hold a DNP or a Ph.D. in nursing.[10]

A DNP degree focuses on advanced clinical practice and leadership. The DNP programs emphasize evidence-based care, system improvement, and public health, addressing Florida's health care needs, and managing chronic conditions.[11]

A Ph.D. degree in nursing is research-focused and prepares nurses for careers as nurse scientists in primarily academic settings.[12]

Titles and Abbreviations

Within the Nurse Practice Act, s. 464.015, F.S., restricts the use of nursing titles and corresponding abbreviations such as RN, LPN, APRN, unless the individual holds a license as such.

Licensees who are found in violation of that section have committed the following acts, which are subject to disciplinary action:[13]

- *Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession.*[14]
- *Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license under which the practitioner is practicing.*[15]

For a nurse who violates either provision, the penalty can range from a reprimand and a $250 fine up to a $700 fine and license suspension.[16]

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[9] Section 464.0123(1)(c), F.S.
[10] Florida Center for Nursing, *State of the Nursing Workforce in Florida 2023*, at 15, *available at* https://issuu.com/flcenterfornursing/docs/state_of_the_nursing_workforce_in_florida?ff (last visited Jan. 28, 2026).
[11] Department of Health, *SB 36 Legislative Bill Analysis* (Dec. 8, 2025) (on file with the Senate Committee on Health Policy).
[12] *Id*.
[13] *Id*.
[14] Section 456.072(1)(a), F.S.
[15] Section 456.072(1)(t), F.S.
[16] 64B9-8.006, F.A.C.

Current law does not explicitly authorize or prohibit the use of the titles "Doctor of Nursing Practice" or "Doctor of Philosophy" and the corresponding abbreviations, "D.N.P." or "Ph.D.," for persons who do not hold those degrees.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 464.015, F.S., to authorize nurses licensed under ch. 464, F.S., to use the titles "Doctor of Nursing Practice" or "Doctor of Philosophy" and the corresponding abbreviations, "D.N.P." or "Ph.D.," if the nurse holds that doctoral degree.

The bill prohibits a nurse who holds a doctoral degree from using the title "doctor" in a clinical setting without clearly specifying his or her profession. Licensees found to be in violation of this new requirement will be subject to disciplinary action under existing grounds for discipline.

Section 2 of the bill provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None identified.

B. Public Records/Open Meetings Issues:

None identified.

C. Trust Funds Restrictions:

None identified.

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:

None identified.

C. Government Sector Impact:

None identified.

VI. Technical Deficiencies:

None identified.

VII. Related Issues:

None identified.

VIII. Statutes Affected:

This bill substantially amends section 464.015 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 February 2, 2026:
The CS clarifies that a licensed nurse may use certain titles and abbreviations consistent with the doctoral degree the nurse has obtained. By removing the word "only" from the underlying bill, out-of-state degree holders are allowed to use the titles and abbreviations enumerated in the bill. Rather than requiring all doctoral degree holders to specify their profession when using the title "doctor," the CS provides that a nurse who holds a doctoral degree may not use the title "doctor" in a clinical setting without clearly specifying his or her profession.

B. Amendments:

None.

690594

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Sharief) recommended the following:

Senate Amendment (with title amendment)

Delete lines 16 - 24

and insert:

(10) A person who is licensed pursuant to this chapter and holds a doctoral degree may use the title "Doctor of Nursing Practice" and the abbreviation "D.N.P." or the title "Doctor of Philosophy" and the abbreviation "Ph.D." in a manner consistent with the doctoral degree such person has obtained. A nurse who holds a doctoral degree may not use the title "doctor" in a

690594

clinical setting without clearly specifying his or her profession.

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

And the title is amended as follows:

Delete lines 3 - 8

and insert:

titles; amending s. 464.015, F.S.; authorizing licensed nurses who hold a doctoral degree to use specified titles and abbreviations in a specified manner; prohibiting nurses who hold a doctoral degree from using a specified title in the clinical setting without clearly specifying their profession; providing an effective date.

By Senator Sharief

35-00001-26 202636__

A bill to be entitled

An act relating to the use of professional nursing titles; amending s. 464.015, F.S.; authorizing persons who hold specified licenses to practice professional nursing or to perform nursing services to use certain titles and abbreviations; requiring doctoral degree holders to specify their profession when using a specified title; providing an effective date.

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

Section 1. Present subsection (10) of section 464.015, Florida Statutes, is redesignated as subsection (11), and a new subsection (10) is added to that section, to read:

464.015 Titles and abbreviations; restrictions; penalty.—

(10) Only a person who holds a license in this state or a multistate license pursuant to s. 464.0095 to practice professional nursing or to perform nursing services is authorized to use the title Doctor of Nursing Practice and the abbreviation "D.N.P.," the title Doctor of Philosophy and the abbreviation "Ph.D.," or other titles or abbreviations authorized under his or her practice act. Doctoral degree holders must specify their profession when using the term "doctor."

Section 2. This act shall take effect July 1, 2026.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 6, 2025

I respectfully request that **Senate Bill # 36**, relating to Use of Professional Nursing Titles, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Barbara Sharief
Florida Senate, District 35

File signed original with committee office

S-020 (03/2004)

Tab 1

The Florida Senate

APPEARANCE RECORD

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

1/2/2026
Meeting Date

HEALTH POLICY
Committee

SB 36
Bill Number or Topic

Amendment Barcode (if applicable)

Name SHARON ROGERS

Phone (954) 789-9489

Address PO BOX 823091
Street

Email sjrogers22@yahoo.com

PEMBROKE PINES FL 33082-3091
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
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2-2-26
Meeting Date

Senate Health Policy
Committee

SB 36
Bill Number or Topic

Amendment Barcode (if applicable)

Name Meredith Fischer

Phone 904-614-0470

Address 616 Pineland Lane
Street

Email mmcfischer@bellsouth.net

St. Johns FL 32259
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2/2/24
Meeting Date

S. Health Policy
Committee

SB 36
Bill Number or Topic

Amendment Barcode (if applicable)

Name Erin Ballas

Phone 850 728 6387

Address 730 E. Park Ave
Street

Email erinballas@paconsultants.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 Nurses Association

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2.2.26
Meeting Date

Health Policy
Committee

SB 36 Nursing Titles
Bill Number or Topic

Amendment Barcode (if applicable)

Name Allison Carvajal Phone 850-727-7087

Address 120 S. Monroe St Email allison@carvajal-fully.com
Street

Tallahassee FL 32312
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Nurse Practitioner Network

☐ 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)

DUPLICATE

The Florida Senate

APPEARANCE RECORD

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

2/2/2026	SB 36
Meeting Date	Bill Number or Topic
Health Policy	
Committee	Amendment Barcode (if applicable)

Name Florida Association of Nurse Anesthesiology Phone 386-589-2224

Address 222 S. Westmonte Drive, Suite 111 Email fana@fana.org

Street

Altamonte Springs FL 32714

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)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

2-2-26
Meeting Date

Health Policy
Committee

SB 36
Bill Number or Topic

Amendment Barcode (if applicable)

Name Monica Barfield

Phone (256) 612-6196

Address 10850 CR 275
Street

Email monicabarfield.amp@gmail.com

Blountstown FL 32424
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 864
INTRODUCER:	Health Policy Committee and Senator Sharief
SUBJECT:	Public Records/Uterine Fibroid Research Database
DATE:	February 3, 2026 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 864 makes confidential and exempt from public records requirements all records and personal identifying information relating to women diagnosed with or treated for uterine fibroids that are submitted to the Department of Health (DOH) for inclusion in the Uterine Fibroid Research Database under s. 381.9312, F.S. Current law prohibits the database from including personal identifying information, which limits the DOH's ability to analyze and understand uterine fibroids in Florida's population.

This exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2031, unless saved by the Legislature from repeal.

The bill contains a statement of public necessity as required by the State Constitution. The bill creates a new public records exemption and, therefore, requires a two-thirds vote of the members of each house who are present and voting for final passage.

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

II. Present Situation:

Uterine Fibroids[1]

Uterine fibroids are tumors inside the uterus that grow on the muscular walls of the uterus. They are almost always benign (not cancerous). Fibroids can grow as a single tumor, or there can be multiple tumors: as small as an apple seed, or as big as a grapefruit. Between 20 and 80 percent of women will have uterine fibroids before they turn 50 years of age. The DOH reports, "Black women are three times more likely to be diagnosed with fibroids than white women. They are also more likely to get them at a younger age, and experience more severe symptoms."

Most fibroids happen in women of reproductive age, and they can complicate getting or staying pregnant. The exact cause of uterine fibroids is unknown, but the hormones estrogen and progesterone play a role. Many people never have symptoms, but some do. Symptoms include abnormal bleeding, pelvic discomfort, pelvic pain, bladder problems, and bowel problems.

Fibroids are treated depending on the impact they have on the woman's life. Treatment may include hormonal contraceptives or surgeries removing fibroids themselves (myomectomy) or the whole uterus (hysterectomy). Additionally, a uterine artery embolization (UAE) can be an alternative to major surgery for some women, stopping blood flow to the fibroids, which causes them to die (and shrink) over time.

Uterine Fibroid Research Database

Section 381.9312, F.S., requires the DOH to develop and maintain an electronic uterine fibroid research database to encourage research on the diagnosis and treatment of uterine fibroids and to ensure women are provided relevant information and health care necessary to prevent and treat uterine fibroids.[2] The statute requires the database to include, at a minimum, the incidence and prevalence of women diagnosed with uterine fibroids in the state; demographic attributes of women diagnosed with uterine fibroids; and treatments and procedures used by health care providers.[3] Health care providers who diagnose or treat a woman with uterine fibroids must submit information to the DOH for inclusion in the database in a form and manner adopted by rule.[4] No such rule has been adopted and the database remains only partially implemented.

Current law prohibits the database from including any personal identifying information of women diagnosed with or treated for uterine fibroids.[5] As a result, the DOH cannot collect personal health information for purposes such as deduplication and matching.[6] Without the ability to collect personal health information to deduplicate records and match individuals across submissions, the DOH indicates that accurately analyzing and understanding uterine fibroids in

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[1] Department of Health, *Diseases & Conditions: Uterine Fibroids*, *available at* http://floridahealth.gov/diseases-and-conditions/disease/uterine-fibroids/ (last visited Jan. 28, 2026).
[2] Section 381.9312(2)(a), F.S.
[3] *Id*.
[4] Section 381.9312(2)(b), F.S.
[5] Section 381.9312(2)(c), F.S.
[6] Department of Health, *HB 196 Legislative Bill Analysis* (received Jan. 28, 2026) (on file with the Senate Committee on Health Policy).

Florida's population is not achievable.[7] The DOH cannot presently reliably determine the number of women with the condition or assess treatment outcomes.[8]

Notwithstanding the statutory restriction on personal identifying information in the database, the DOH reports it employs a defense-in-depth security approach with multiple security layers to protect the deidentified data in the uterine fibroid research database.[9]

Access to Public Records - Generally

The State Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[10] The right to inspect or copy applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[11]

Additional requirements and exemptions related to public records are found in various statutes and rules, depending on the branch of government involved. For instance, s. 11.0431, F.S., provides public access requirements for legislative records. Relevant exemptions are codified in s. 11.0431(2)-(3), F.S., and adopted in the rules of each house of the legislature.[12] Florida Rule of Judicial Administration 2.420 governs public access to judicial branch records.[13] Lastly, ch. 119, F.S., known as the Public Records Act, provides requirements for public records held by executive agencies.

Executive Agency Records – The Public Records Act

The Public Records Act provides that all state, county, and municipal records are open for personal inspection and copying by any person, and that providing access to public records is a duty of each agency.[14]

Section 119.011(12), F.S., defines "public records" to include:

> [a]ll documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or

[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] FLA. CONST. art. I, s. 24(a).
[11] *Id*. *See also*, *Sarasota Citizens for Responsible Gov't v. City of Sarasota*, 48 So. 3d 755, 762-763 (Fla. 2010).
[12] *See* Rule 1.48, *Rules and Manual of the Florida Senate*, (2022-2024) and Rule 14.1, *Rules of the Florida House of Representatives*, Edition 2, (2022-2024).
[13] *State v. Wooten*, 260 So. 3d 1060 (Fla. 4th DCA 2018).
[14] Section 119.01(1), F.S. Section 119.011(2), F.S., defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."

> received pursuant to law or ordinance or in connections with the transaction of official business by any agency.

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business that are used to "perpetuate, communicate, or formalize knowledge of some type."[15]

The Florida Statutes specify conditions under which public access to public records must be provided. The Public Records Act guarantees every person's right to inspect and copy any public record at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.[16] A violation of the Public Records Act may result in civil or criminal liability.[17]

The Legislature may exempt public records from public access requirements by passing a general law by a two-thirds vote of both the House and the Senate.[18] The exemption must state with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish the stated purpose of the exemption.[19]

General exemptions from the public records requirements are contained in the Public Records Act.[20] Specific exemptions often are placed in the substantive statutes relating to a particular agency or program.[21]

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." There is a difference between records the Legislature has determined to be exempt from the Public Records Act and those which the Legislature has determined to be exempt from the Public Records Act *and confidential*.[22] Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute.[23] Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances.[24]

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[15] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc*., 379 So. 2d 633, 640 (Fla. 1980).
[16] Section 119.07(1)(a), F.S.
[17] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[18] FLA. CONST. art. I, s. 24(c).
[19] *Id*. *See, e.g.*, *Halifax Hosp. Medical Center v. News-Journal Corp.,* 724 So. 2d 567 (Fla. 1999) (holding that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption); *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004) (holding that a statutory provision written to bring another party within an existing public records exemption is unconstitutional without a public necessity statement).
[20] *See, e.g.*, s. 119.071(1)(a), F.S. (exempting from public disclosure examination questions and answer sheets of examinations administered by a governmental agency for the purpose of licensure).
[21] *See, e.g.*, s. 213.053(2)(a), F.S. (exempting from public disclosure information contained in tax returns received by the Department of Revenue).
[22] *WFTV, Inc. v. The Sch. Bd. of Seminole County*, 874 So. 2d 48, 53 (Fla. 5th DCA 2004).
[23] *Id.*
[24] *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991).

Open Government Sunset Review Act

The provisions of s. 119.15, F.S., known as the Open Government Sunset Review Act[25] (the Act), prescribe a legislative review process for newly created or substantially amended[26] public records or open meetings exemptions, with specified exceptions.[27] The Act requires the repeal of such exemption on October 2 of the fifth year after its creation or substantial amendment, unless the Legislature reenacts the exemption.[28]

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[29] An exemption serves an identifiable purpose if the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption, and it meets one of the following purposes:

- It allows the state or its political subdivisions to effectively and efficiently administer a governmental program, and administration would be significantly impaired without the exemption;[30]
- It protects sensitive, personal information, the release of which would be defamatory, cause unwarranted damage to the good name or reputation of the individual, or would jeopardize the individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[31] or
- It protects information of a confidential nature concerning entities, such as trade or business secrets.[32]

The Act also requires specified questions to be considered during the review process.[33] In examining an exemption, the Act directs the Legislature to question the purpose and necessity of reenacting the exemption.

If the exemption is continued and expanded, then a public necessity statement and a two-thirds vote for passage are again required.[34] If the exemption is continued without substantive changes or if the exemption is continued and narrowed, then a public necessity statement and a two-thirds

[25] Section 119.15, F.S.
[26] An exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings as well as records. Section 119.15(4)(b), F.S.
[27] Section 119.15(2)(a) and (b), F.S., provides that exemptions required by federal law or applicable solely to the Legislature or the State Court System are not subject to the Open Government Sunset Review Act.
[28] Section 119.15(3), F.S.
[29] Section 119.15(6)(b), F.S.
[30] Section 119.15(6)(b)1., F.S.
[31] Section 119.15(6)(b)2., F.S.
[32] Section 119.15(6)(b)3., F.S.
[33] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[34] *See generally* s. 119.15, F.S.

vote for passage are *not* required. If the Legislature allows an exemption to expire, the previously exempt records will remain exempt unless otherwise provided by law.[35]

III. Effect of Proposed Changes:

Section 1 amends s. 381.9312, F.S., relating to the Uterine Fibroid Research Database, to provide that all records and personal identifying information relating to women diagnosed with or treated for uterine fibroids which are submitted to the DOH under that section, are confidential and exempt from s. 119.07(1), F.S. (public records inspection and copying) and s. 24(a), Art. I of the State Constitution (constitutional right of access to public records).

The exemption is subject to the Open Government Sunset Review Act under s. 119.15, F.S., and is repealed on October 2, 2031, unless reviewed and saved from repeal by the Legislature.

Section 2 provides the constitutionally required public necessity statement, finding that confidentiality is necessary to protect privacy interests associated with personal health information, including information that could implicate federal patient privacy laws like the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and to support the DOH's ability to administer the uterine fibroid research database and related epidemiological research and tracking activities.

Section 3 provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Not applicable.

B. Public Records/Open Meetings Issues:

Vote Requirement

Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records disclosure requirements. CS/SB 864 creates a new exemption by making all records and personal identifying information relating to women diagnosed with or treated for uterine fibroids that are submitted to the DOH under s. 381.9312, F.S., confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. Accordingly, the bill requires a two-thirds vote for final passage.

Public Necessity Statement

Article I, s. 24(c) of the State Constitution requires a bill creating or expanding an exemption to the public records disclosure requirements to state with specificity the public necessity justifying the exemption. Section 2 of the bill contains a statement of

[35] Section 119.15(7), F.S.

public necessity finding, in part, that the DOH is unable to effectively implement the legislative purpose of the uterine fibroid research database without access to the records and information made confidential and exempt by the bill. The statement further explains that the records include personal medical information, the disclosure of which would violate federal patient privacy laws, including HIPAA, and that confidentiality is necessary to protect privacy rights and promote the DOH's epidemiological research and tracking activities.

Breadth of Exemption

Article I, s. 24(c) of the State Constitution requires an exemption from the public records requirements to be no broader than necessary to accomplish the stated purpose of the law. CS/SB 864 applies to a defined subset of information: records and personal identifying information relating to women diagnosed with or treated for uterine fibroids, only when such information is submitted to the DOH under s. 381.9312, F.S. The bill's stated purposes are to protect the privacy rights of women diagnosed with and treated for uterine fibroids and to promote the DOH's effective administration of its epidemiological research and tracking activities for the uterine fibroid research database. Based on these limitations and the stated purposes, the exemption does not appear to be broader than necessary to accomplish the purpose of the law.

C. Trust Funds Restrictions:

None identified.

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:

None identified.

C. Government Sector Impact:

None identified.

VI. Technical Deficiencies:

None identified.

VII. Related Issues:

None identified.

VIII. Statutes Affected:

This bill substantially amends section 381.9312 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 February 2, 2026:
The CS provides an effective date of July 1, 2026, replacing the contingent effective date in the underlying bill.

B. Amendments:

None.

338936

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Sharief) recommended the following:

Senate Amendment (with title amendment)

Delete lines 45 - 48

and insert:

Section 3. This act shall take effect July 1, 2026.

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

And the title is amended as follows:

Delete line 9

and insert:

338936

providing an effective date.

By Senator Sharief

35-01127-26 2026864__

A bill to be entitled

An act relating to public records; amending s. 381.9312, F.S.; providing an exemption from public records requirements for certain records and personal identifying information submitted to the Department of Health for inclusion in the uterine fibroid research database; providing for future legislative review and repeal; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Subsection (4) is added to section 381.9312, Florida Statutes, to read:

381.9312 Uterine fibroid research database; education and public awareness.—

(4) PUBLIC RECORDS EXEMPTION.—All records and personal identifying information relating to women diagnosed with or treated for uterine fibroids which is submitted to the department under this section are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2031, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity to make all records and personal identifying information relating to women diagnosed with or treated for uterine fibroids which is submitted to the Department of Health

under s. 381.9312, Florida Statutes, confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. The Department of Health is unable to effectively implement the legislative purpose of the uterine fibroid research database, created under s. 381.9312, Florida Statutes, without access to these records and information, which include personal medical information, the disclosure of which would violate federal patient privacy laws, including the Health Insurance Portability and Accountability Act of 1996. Therefore, the Legislature finds that it is a public necessity to make such records and information held by the department confidential and exempt to protect the privacy rights of women diagnosed with and treated for uterine fibroids in this state and promote the effective administration of the department's epidemiological research and tracking activities.

Section 3. This act shall take effect on the same date that SB 196 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: December 22nd, 2025

I respectfully request that **Senate Bill #864**, relating to Public Records Uterine Fibroid Research Database , 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 Committee on Health Policy

BILL:	CS/SB 268
INTRODUCER:	Health Policy Committee and Senator Rodriguez
SUBJECT:	Public Records/Emergency Physicians
DATE:	February 3, 2026
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 268 exempts from public records disclosure requirements certain identifying and location information of current emergency department physicians (defined in the bill as allopathic and osteopathic physicians who perform duties in a hospital emergency department), their spouses, and their children up to age 26. The bill exempts from public disclosure the home addresses, personal telephone numbers, and dates of birth of the physician and the physician's spouse and such children. The bill also exempts the place of employment of the physician's spouse and children. In addition, the exemption applies to the names and locations of the schools and day care facilities attended by the physician's children.

The bill requires custodial agencies that are not the employer of an emergency department physician to maintain the exempt status of certain personal information upon receipt of a notarized, sworn request affirming eligibility. The exemption remains in effect until the individual no longer qualifies and must be withdrawn by the requester when no longer applicable.

This exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2031, unless saved by the Legislature from repeal.

The bill contains a statement of public necessity as required by the State Constitution. The bill creates a new public records exemption and, therefore, requires a two-thirds vote of the members present and voting for final passage in each house of the Legislature.

This bill is not expected to impact state and local government revenues and expenditures.

This bill provides an effective date of July 1, 2026.

II. Present Situation:

Access to Public Records - Generally

The State Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] The right to inspect or copy applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

Additional requirements and exemptions related to public records are found in various statutes and rules, depending on the branch of government involved. For instance, s. 11.0431, F.S., provides public access requirements for legislative records. Relevant exemptions are codified in s. 11.0431(2)-(3), F.S., and adopted in the rules of each house of the legislature.[3] Florida Rule of Judicial Administration 2.420 governs public access to judicial branch records.[4] Lastly, ch. 119, F.S., known as the Public Records Act, provides requirements for public records held by executive agencies.

Executive Agency Records – The Public Records Act

The Public Records Act provides that all state, county, and municipal records are open for personal inspection and copying by any person, and that providing access to public records is a duty of each agency.[5]

Section 119.011(12), F.S., defines "public records" to include:

> [a]ll documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connections with the transaction of official business by any agency.

[1] FLA. CONST. art. I, s. 24(a).
[2] *Id*. *See* also, *Sarasota Citizens for Responsible Gov't v. City of Sarasota*, 48 So. 3d 755, 762-763 (Fla. 2010).
[3] *See* Rule 1.48, *Rules and Manual of the Florida Senate*, (2022-2024) and Rule 14.1, *Rules of the Florida House of Representatives*, Edition 2, (2022-2024).
[4] *State v. Wooten*, 260 So. 3d 1060 (Fla. 4th DCA 2018).
[5] Section 119.01(1), F.S. Section 119.011(2), F.S., defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business that are used to "perpetuate, communicate, or formalize knowledge of some type."[6]

The Florida Statutes specify conditions under which public access to public records must be provided. The Public Records Act guarantees every person's right to inspect and copy any public record at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.[7] A violation of the Public Records Act may result in civil or criminal liability.[8]

The Legislature may exempt public records from public access requirements by passing a general law by a two-thirds vote of both the House and the Senate.[9] The exemption must state with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish the stated purpose of the exemption.[10]

General exemptions from the public records requirements are contained in the Public Records Act.[11] Specific exemptions often are placed in the substantive statutes relating to a particular agency or program.[12]

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." There is a difference between records the Legislature has determined to be exempt from the Public Records Act and those which the Legislature has determined to be exempt from the Public Records Act *and confidential*.[13] Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute.[14] Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances.[15]

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[6] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc*., 379 So. 2d 633, 640 (Fla. 1980).
[7] Section 119.07(1)(a), F.S.
[8] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[9] FLA. CONST. art. I, s. 24(c).
[10] *Id*. *See, e.g.*, *Halifax Hosp. Medical Center v. News-Journal Corp.,* 724 So. 2d 567 (Fla. 1999) (holding that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption); *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004) (holding that a statutory provision written to bring another party within an existing public records exemption is unconstitutional without a public necessity statement).
[11] *See, e.g.*, s. 119.071(1)(a), F.S. (exempting from public disclosure examination questions and answer sheets of examinations administered by a governmental agency for the purpose of licensure).
[12] *See, e.g.*, s. 213.053(2)(a), F.S. (exempting from public disclosure information contained in tax returns received by the Department of Revenue).
[13] *WFTV, Inc. v. The Sch. Bd. of Seminole County*, 874 So. 2d 48, 53 (Fla. 5th DCA 2004).
[14] *Id.*
[15] *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991).

Open Government Sunset Review Act

The provisions of s. 119.15, F.S., known as the Open Government Sunset Review Act[16] (the Act), prescribe a legislative review process for newly created or substantially amended[17] public records or open meetings exemptions, with specified exceptions.[18] The Act requires the repeal of such exemption on October 2 of the fifth year after its creation or substantial amendment, unless the Legislature reenacts the exemption.[19]

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[20] An exemption serves an identifiable purpose if the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption, and it meets one of the following purposes:

- It allows the state or its political subdivisions to effectively and efficiently administer a governmental program, and administration would be significantly impaired without the exemption;[21]
- It protects sensitive, personal information, the release of which would be defamatory, cause unwarranted damage to the good name or reputation of the individual, or would jeopardize the individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[22] or
- It protects information of a confidential nature concerning entities, such as trade or business secrets.[23]

The Act also requires specified questions to be considered during the review process.[24] In examining an exemption, the Act directs the Legislature to question the purpose and necessity of reenacting the exemption.

If the exemption is continued and expanded, then a public necessity statement and a two-thirds vote for passage are again required.[25] If the exemption is continued without substantive changes or if the exemption is continued and narrowed, then a public necessity statement and a two-thirds

[16] Section 119.15, F.S.
[17] An exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings as well as records. Section 119.15(4)(b), F.S.
[18] Section 119.15(2)(a) and (b), F.S., provides that exemptions required by federal law or applicable solely to the Legislature or the State Court System are not subject to the Open Government Sunset Review Act.
[19] Section 119.15(3), F.S.
[20] Section 119.15(6)(b), F.S.
[21] Section 119.15(6)(b)1., F.S.
[22] Section 119.15(6)(b)2., F.S.
[23] Section 119.15(6)(b)3., F.S.
[24] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[25] *See generally* s. 119.15, F.S.

vote for passage are *not* required. If the Legislature allows an exemption to expire, the previously exempt records will remain exempt unless otherwise provided by law.[26]

III. Effect of Proposed Changes:

Section 1 creates a public records exemption for specified personal identifying and location information of current emergency department physicians, their spouses, and their children up to age 26. For purposes of the exemption, an "emergency department physician" is a physician licensed under ch. 458 or ch. 459, F.S., whose duties are performed in a hospital emergency department licensed under ch. 395, F.S. The following information will be exempt from public disclosure under the bill:

- The home addresses, personal telephone numbers, and dates of birth of current emergency department physicians;
- The names, home addresses, personal telephone numbers, dates of birth, and places of employment of the spouses and applicable children of such physicians; and
- The names and locations of schools and day care facilities attended by applicable children of such physicians.

Under the bill, an individual who is a current emergency department physician, or the spouse or child of such a physician, may request that a custodial agency maintain the exempt status of his or her specified personal information. To do so, the individual must submit a written and notarized request to the custodial agency. The request must include a sworn statement specifying the statutory basis for the exemption and affirming the individual's eligibility.

The custodial agency must preserve the exempt status of the information upon receipt of a request that meets the requirements established in the bill. The agency must maintain the exemption until the qualifying conditions no longer apply to the individual who is the subject of the exemption.

The bill also imposes a duty on individuals who submit such requests to notify the custodial agency if the basis for the exemption no longer applies.

Pursuant to s. 119.071(4)(d)6., F.S., the new exemption applies to information held by an agency before, on, or after July 1, 2026 (the effective date of the exemption).[27]

Consistent with s. 119.15, F.S., the new exemptions will expire on October 2, 2031, unless reviewed and saved from repeal by the Legislature.

Section 2 provides the constitutionally required public necessity statement, citing emergency department physicians' heightened vulnerability to violence, harassment, intimidation, stalking, and related harms arising from the nature of emergency department encounters, and finding that the potential harm from disclosure outweighs any public benefit.

Section 3 provides that the bill takes effect on July 1, 2026.

[26] Section 119.15(7), F.S.
[27] *See* s. 119.071(4)(d)6., F.S.

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:

Vote Requirement

Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records disclosure requirements. This bill enacts a new exemption for certain addresses, personal phone numbers, and other details of current emergency department physicians and their spouses and applicable children and, thus, the bill requires a two-thirds vote of each house of the Legislature to be enacted.

Public Necessity Statement

Article I, s. 24(c) of the State Constitution requires a bill creating or expanding an exemption to the public records disclosure requirements to state with specificity the public necessity justifying the exemption. Section 2 of the bill contains a statement of public necessity for the exemption which provides that emergency department physicians and their families may be subject to threats, harassment, intimidation, stalking, and other acts of violence arising from the physicians' work in hospital emergency departments. The statement further provides that disclosure of the exempt information could increase the risk of such harm and that protecting this information is necessary because the potential danger to emergency department physicians and their families outweighs the public benefit of disclosure.

Breadth of Exemption

Article I, section 24(c) of the State Constitution requires an exemption to the public records disclosure requirements to be no broader than necessary to accomplish the stated purpose of the law. The purpose of the proposed law is to protect identifying and location information that could compromise the safety of emergency department physicians and their families. This bill exempts current emergency department physicians, their spouses, and children younger than 26 years of age from the public records disclosure requirements. The records exempted in the CS are narrowly tailored to the most relevant safety concerns, limited to physicians who currently work in emergency departments, and the individual seeking the protection of the exemption must specifically request the exemption from the custodial agency. Thus, the exemption does not appear to be broader than necessary to accomplish the purpose of the law.

C. Trust Funds Restrictions:

None identified.

D. State Tax or Fee Increases:

None identified.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The private sector will be subject to the cost associated with an agency's review and redactions of exempt records in response to a public records request.

C. Government Sector Impact:

The Department of Health has indicated that it would communicate the new exemption to physicians through multiple media platforms and notes that it is unknown how many licensees would request this exemption.

This bill may cause a minimal increase in workload on agencies[28] holding records that contain personal identifying information of public officers as well as their spouses and children because staff responsible for complying with public record requests may require training related to the new public record exemption. Additionally, agencies may incur costs associated with redacting the exempt information prior to releasing a record. However, the workload will likely be absorbed within current resources.

VI. Technical Deficiencies:

None identified.

VII. Related Issues:

None identified.

VIII. Statutes Affected:

This bill substantially amends section 119.071 of the Florida Statutes.

[28] Department of Health, *SBl 268 Legislative Bill Analysis* (Jan. 9, 2026) (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 February 2, 2026:
The CS narrows the exemption in the underlying bill by limiting it to current emergency department physicians (not former), their spouses, and their children up to age 26. It removes the physician's place of employment and photographs from the covered information, clarifies that personal phone numbers are protected, and requires physicians and their family members to request the exemption from the custodial agency to receive the exemption. The CS requires that a requested exemption be withdrawn by the requester when it is no longer applicable.

B. Amendments:

None.

519420

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Rodriguez) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (l) is added to subsection (5) of section 119.071, Florida Statutes, to read:

119.071 General exemptions from inspection or copying of public records.—

(5) OTHER PERSONAL INFORMATION.—

(l)1. For purposes of this paragraph, the term "emergency

519420

department physician" means a physician licensed under chapter 458 or chapter 459 whose duties are performed in a hospital emergency department licensed under chapter 395.

2. The home addresses, personal telephone numbers, and dates of birth of current emergency department physicians; the names, home addresses, personal telephone numbers, dates of birth, and places of employment of the spouses and children younger than 26 years of age of such emergency department physicians; and the names and locations of schools and day care facilities attended by the children younger than 26 years of age of such emergency department physicians are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

3. The exemption in subparagraph 2. applies to information held by an agency before, on, or after the effective date of the exemption.

4. An agency that is the custodian of information specified in subparagraph 2. and that is not the employer of the emergency department physician must maintain the exempt status of that information only if the individual requests the maintenance of an exemption under subparagraph 2. on the basis of eligibility as a current emergency department physician or the spouse or child of such emergency department physician and the individual submits a written and notarized request for maintenance of the exemption to the custodial agency. The request must state under oath the statutory basis for the individual's exemption request and confirm the individual's eligibility for the exemption. An individual who has submitted such a request has a duty to withdraw the request if the exemption no longer applies to the individual. If a custodial agency receives a request meeting the

519420

requirements of this subparagraph, the custodial agency must maintain the exempt status of such information applicable to the individual until the qualifying conditions for the exemption under subparagraph 2. no longer apply to the individual subject to the exemption.

5. This paragraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2031, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that the home addresses, personal telephone numbers, and dates of birth of current emergency department physicians; the names, home addresses, personal telephone numbers, and places of employment of the spouses and children younger than 26 years of age of such emergency department physicians; and the names and locations of schools and day care facilities attended by the children younger than 26 years of age of such emergency department physicians be made exempt from public records requirements. Emergency department physicians, by the nature of their duties, are often placed in traumatic circumstances in which loss of life and severe bodily injuries have occurred. Such emergency department physicians are particularly vulnerable to physical violence, harassment, and intimidation perpetrated by patients or relatives of patients who can be violent, angry, or mentally unstable. As a result, the Legislature finds that the release of personal identifying and location information of emergency department physicians, or of the spouses and children of such emergency department physicians, could place them in danger of being physically or emotionally harmed or stalked by a

519420

person who has a hostile reaction to his or her encounter with such physicians. The Legislature further finds that the harm that may result from the release of such personal identifying and location information outweighs any public benefit that may be derived from the disclosure of the information.

Section 3. This act shall take effect July 1, 2026.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to public records; amending s. 119.071, F.S.; defining the term "emergency department physician"; providing exemptions from public records requirements for the personal identifying and location information of current emergency department physicians and the spouses and certain children of such emergency department physicians; providing for retroactive application of the exemption; requiring certain agencies that are custodians of the exempt information to maintain the exempt status of such information under certain circumstances; specifying procedures for requesting an agency to maintain the exempt status of such information; providing that an individual has a duty to withdraw a request if the exemption no longer applies to him or her; requiring custodial agencies to maintain the exempt status of such information until the exemption no longer applies to the individual;

519420

providing for future legislative review and repeal of the exemption; providing a statement of public necessity; providing an effective date.

By Senator Rodriguez

40-00249-26 2026268__

A bill to be entitled

An act relating to public records; amending s. 119.071, F.S.; defining the term "emergency physician"; providing exemptions from public records requirements for the personal identifying and location information of current or former emergency physicians and the spouses and children of such emergency physicians; providing for retroactive application of the exemption; providing for future legislative review and repeal of the exemption; providing a statement of public necessity; providing an effective date.

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

Section 1. Paragraph (l) is added to subsection (5) of section 119.071, Florida Statutes, to read:

119.071 General exemptions from inspection or copying of public records.—

(5) OTHER PERSONAL INFORMATION.—

(l)1. For purposes of this paragraph, the term "emergency physician" means a physician licensed under chapter 458 or chapter 459 whose duties are performed in a hospital emergency department licensed under chapter 395.

2. The home addresses, telephone numbers, dates of birth, places of employment, and photographs of current or former emergency physicians; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such emergency physicians; and the names and locations of schools and day care facilities attended by the

children of such emergency physicians are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

3. The exemption in subparagraph 2. applies to information held by an agency before, on, or after the effective date of the exemption.

4. This paragraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2031, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that the home addresses, telephone numbers, dates of birth, places of employment, and photographs of current or former emergency physicians; the names, home addresses, telephone numbers, and places of employment of the spouses and children of such emergency physicians; and the names and locations of schools and day care facilities attended by the children of such emergency physicians be made exempt from public records requirements. Emergency physicians, by the nature of their duties, are often placed in traumatic circumstances in which loss of life and severe bodily injuries have occurred. Such emergency physicians are particularly vulnerable to physical violence, harassment, and intimidation perpetrated by patients or relatives of patients who can be violent, angry, or mentally unstable. As a result, the Legislature finds that the release of identifying and location information of emergency physicians, or of the spouses and children of such emergency physicians, could place them in danger of being physically or emotionally harmed or stalked by a person who has a hostile reaction to his or her encounter with such physicians. The

Legislature further finds that the harm that may result from the release of such identifying and location information outweighs any public benefit that may be derived from the disclosure of the information.

Section 3. This act shall take effect July 1, 2026.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 28, 2026

I respectfully request that **Senate Bill 268**, relating to Public Records/Emergency Physicians, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 40

File signed original with committee office

S-020 (03/2004)

Tab 3

The Florida Senate

APPEARANCE RECORD

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

02 Feb 2026
Meeting Date

Health Policy
Committee

260
Bill Number or Topic

—
Amendment Barcode (if applicable)

Name Dr. Shawn Patterson Phone 239-949-4628

Address 15420 Collier Blvd ~~Naples, FL 34120~~ Email shawn_patterson@teamhealth.com
Street

Naples FL 34120
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)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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02/02/2026
Meeting Date

Senate Health Policy
Committee

SB 268
Bill Number or Topic

Amendment Barcode (if applicable)

Name Katie Larsen

Phone 239 776 6000

Address 9800 S. Healthpark Drive Suite 405
Street

Email katie.larsen@leehealth.org

Fort Myers FL 33908
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:
Lee Health System, Inc

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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02 Feb. 2026
Meeting Date

Health Policy
Committee

268
Bill Number or Topic

—
Amendment Barcode (if applicable)

Name Matthew Holliday

Phone 239-826-7864

Address 350 7th St. N
Street

Email Matthew.holl.dy@nchmd.org

Naples FL 34102
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: Naples Comprehensive Health (NCH)

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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Feb. 2, 24
Meeting Date

Health Policy
Committee

268
Bill Number or Topic

Amendment Barcode (if applicable)

Name Toni Large

Phone (850) 556-1461

Address 1100 Brookwood Dr
Street

Email toni@largestrategies.com

Tallahassee, FL 32308
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

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

Florida College of Emergency Physicians

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2/2
Meeting Date

HP
Committee

SB 208
Bill Number or Topic

Amendment Barcode (if applicable)

Name DAVID MICA

Phone

Address
Street

Email

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: FL Hospital 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 Committee on Health Policy

BILL:	SB 844
INTRODUCER:	Senator Jones
SUBJECT:	Sickle Cell Disease Care Management and Treatment Continuing Education
DATE:	January 30, 2026 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AHS	
3.			FP	

I. Summary:

SB 844 creates s. 456.0311, F.S., to require allopathic and osteopathic physicians and nurses licensed under part I of ch. 464, F.S.,[1] to complete a two-hour continuing education (CE) course, approved by the applicable board, on sickle cell disease (SCD) care management.

The bill specifies what must be included in the course and requires each license or certificate holder to submit confirmation of have completed such a course to their applicable board. The bill allows applicable boards to approve additional equivalent courses that may be used to satisfy the CE requirement and to include the required hours in any total continuing education required for the practitioner, so long as the practitioner is not required to take less than 30 hours of CE. Failure to comply with the CE requirement constitutes grounds for disciplinary action. The bill grants each applicable board authority to adopt rules to implement these provisions.

Additionally, the bill adds the treatment of pain for patients with sickle cell disease to what must be included for CE courses for persons registered to prescribe controlled substances.

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

II. Present Situation:

Sickle Cell Disease

SCD affects approximately 100,000 Americans and is the most prevalent inherited blood disorder in the U.S.[2] SCD affects mostly, but not exclusively, persons of African ancestry. SCD

[1] Part I of ch. 464, F.S., is the Nurse Practice Act and governs the licensure and certification of registered nurses, licensed practical nurses, and advanced practice registered nurses.

[2] National Institutes of Health, National Heart, Lung, and Blood Institute, *What is Sickle Cell Disease?, available at* https://www.nhlbi.nih.gov/health/sickle-cell-disease (last visited Jan. 29, 2026).

is a group of inherited disorders in which abnormal hemoglobin cause red blood cells to buckle into a sickle shape. The deformed red blood cells damage blood vessels and, over time, contribute to a cascade of negative health effects beginning in infancy, such as intense vaso-occlusive pain episodes, strokes, organ failure, and recurrent infections.[3,4] The severity of complications generally worsens with age, but treatment and prevention strategies can mitigate complications and lengthen the lives of those suffering from SCD.[5]

A person who carries a single gene for SCD has the sickle cell trait. Individuals with the sickle cell trait do not have SCD, and under normal conditions, they are generally asymptomatic. However, they are carriers of SCD and have an increased likelihood of having a child with SCD.

Continuing Education

Physicians licensed under chs. 458 and 459, F.S., and practitioners licensed or certified under part I of ch. 464, F.S., are required to complete varying amounts of continuing education to maintain their licensure or certification.

- CE requirements for specified professions include:
  - Section 456.013(6), F.S., requires physicians licensed under chs. 458 and 459, F.S., to complete a minimum of 40 hours of CE every two years and allows the boards to require that up to one hour be in the area of risk management or cost containment.
  - Sections 458.347 and 459.022, F.S., require physician assistants (PA) to complete a minimum of 10 hours of CE. Three of the 10 hours must consist of a course on the safe and effective prescribing of controlled substances.
  - Part I of ch. 464, F.S., requires registered nurses (RN), licensed practical nurses (LPN), and advanced practice registered nurses (APRN) to take up to 30 hours of CE as a condition of licensure or certificate renewal unless they are certified and certain accredited health care specialty programs. As part of their CE and regardless of being exempt from CE requirements due to certification:
    - APRNs are required to take a three hour course on the safe and effective prescribing of controlled substances; and
    - All nurses licensed or certified under part I of ch. 464, F.S., are required to take a two hour CE on human trafficking.
- General CE requirements for health care practitioners include:
  - Section 456.013(7), F.S., requires all practitioners licensed or certified by the Department of Health (DOH) to complete a two hour course relating to the prevention of medical errors every two years which count toward the total number of CE hours required for the practitioner's profession.

[3] Centers for Disease Control and Prevention, *About Sickle Cell Disease, available at* About Sickle Cell Disease | Sickle Cell Disease (SCD) | CDC (last visited Jan. 29, 2026).
[4] Florida Agency for Health Care Administration, *Florida Medicaid Study of Enrollees with Sickle Cell Disease (2023), available at* https://ahca.myflorida.com/content/download/20771/file/Florida_Medicaid_Study_of_Enrollees_with_Sickle_Cell_Disease.pdf (last visited Jan. 29, 2026).
[5] Centers for Disease Control and Prevention, *Complications of Sickle Cell Disease, available at* Complications of Sickle Cell Disease | Sickle Cell Disease (SCD) | CDC (last visited Jan. 29, 2026).

- Section 456.0301, F.S., requires each person registered with the United States Drug Enforcement Agency (DEA) and authorized to prescribe controlled substances to complete a two hour CE course on prescribing controlled substances.
- Sections 456.031, 456.033, and 456.0341, F.S., require persons licensed under multiple chapters of law, including physicians and nurses, to take CE courses on domestic violence, HIV[6] and AIDS,[7] and human trafficking.

III. Effect of Proposed Changes:

Section 1 amends s. 456.3031, F.S., to require that the two-hour CE for practitioners registered with the DEA and authorized to prescribe controlled substances include information on the treatment of pain for patients with SCD.

Section 2 creates s. 456.0311, F.S., to require physicians, PAs, RNs, LPNs, and APRNs, to complete one two-hour, board-approved CE course on SCD care management as part of the first licensure or certification renewal. The course is required to consist of education specific to SCD and sickle cell traits, including, but not limited to, evidence-based treatment protocols for patients of all ages, continuing patient and family education, periodic comprehensive evaluations and other disease-specific health maintenance services, psychosocial care, genetic counseling, and pain management. Each licensee or certificate holder is required to submit confirmation of having completed such course on a form provided by the applicable board when submitting fees for the first renewal.

In addition to the board-approved course, each applicable board may approve additional equivalent courses that may be used to satisfy the CE requirement. Also, each licensing board may include the hours required for completion of the CE in the total hours of continuing education required by law for such profession unless the CE requirements for such profession consist of fewer than 30 hours biennially. If a person holds two or more licenses subject to taking the CE course, completing the course once is sufficient for their CE requirement for all of their licenses.

The bill specifies that failure to comply with the CE requirements is grounds for disciplinary action under each respective practice act and under s. 456.072(1)(k), F.S., and, in addition to any discipline, the licensee must be required to complete the required course.

The bill grants rulemaking authority to each applicable board to implement the new requirements.

Section 3 provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[6] Human immunodeficiency virus.
[7] Acquired immunodeficiency syndrome.

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:

SB 844 may have an indeterminate negative fiscal impact on practitioners if they are required to pay to take the additional CE course.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 456.0301of the Florida Statutes.

This bill creates section 456.0311 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 Jones

34-01011-26 2026844__

A bill to be entitled

An act relating to sickle cell disease care management and treatment continuing education; amending s. 456.0301, F.S.; revising requirements for a continuing education course on prescribing controlled substances which health care practitioners are required to complete; creating s. 456.0311, F.S.; requiring the applicable licensing boards for specified health care professions to require a 2-hour continuing education course on sickle cell disease care management as part of the first licensure or certification renewal; specifying requirements for the course; specifying the procedure for licensees and certificateholders to submit confirmation of completing the course; authorizing the applicable boards to approve additional equivalent courses to satisfy the requirement; authorizing the applicable boards to include the course hours in the total hours of continuing education required for the applicable profession, with an exception; authorizing health care practitioners holding two or more licenses or certificates subject to the course requirement to show proof of completion of one course to satisfy the requirement for all such licenses or certificates; providing for disciplinary action; authorizing the applicable boards to adopt rules; providing an effective date.

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

Section 1. Paragraph (a) of subsection (1) of section 456.0301, Florida Statutes, is amended to read:

456.0301 Requirement for instruction on controlled substance prescribing.—

(1)(a) The appropriate board shall require each person registered with the United States Drug Enforcement Administration and authorized to prescribe controlled substances pursuant to 21 U.S.C. s. 822 to complete a board-approved 2-hour continuing education course on prescribing controlled substances offered by a statewide professional association of physicians in this state that is accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 Credit or the American Osteopathic Category 1-A continuing medical education credit as part of biennial license renewal. The course must include information on the current standards for prescribing controlled substances, particularly opiates; alternatives to these standards; nonpharmacological therapies; prescribing emergency opioid antagonists; ~~and~~ the risks of opioid addiction following all stages of treatment in the management of acute pain; and the treatment of pain for patients with sickle cell disease. The course may be offered in a distance learning format and must be included within the number of continuing education hours required by law. The department may not renew the license of any prescriber registered with the United States Drug Enforcement Administration to prescribe controlled substances who has failed to complete the course. The course must be completed by January 31, 2019, and at each subsequent renewal. This paragraph does

not apply to a licensee who is required by his or her applicable practice act to complete a minimum of 2 hours of continuing education on the safe and effective prescribing of controlled substances.

Section 2. Section 456.0311, Florida Statutes, is created to read:

456.0311 Requirements for instruction on sickle cell disease.—

(1)(a) The applicable board shall require each person licensed or certified under chapter 458, chapter 459, or part I of chapter 464 to complete one 2-hour continuing education course, approved by the applicable board, on sickle cell disease care management as part of the first licensure or certification renewal. The course must consist of education specific to sickle cell disease and sickle cell traits, including, but not limited to, evidence-based treatment protocols for patients of all ages, continuing patient and family education, periodic comprehensive evaluations and other disease-specific health maintenance services, psychosocial care, genetic counseling, and pain management.

(b) Each licensee or certificateholder must submit confirmation of having completed such course on a form provided by the applicable board when submitting fees for the first renewal.

(c) The applicable board may approve additional equivalent courses that may be used to satisfy the requirements of paragraph (a). Each licensing board that requires a licensee to complete an educational course pursuant to this section may include the hours required for completion of the course in the

total hours of continuing education required by law for such profession unless the continuing education requirements for such profession consist of fewer than 30 hours biennially.

(d) Any person holding two or more licenses subject to the provisions of this section may show proof of having taken one board-approved course to satisfy the requirements of paragraph (a) for purposes of relicensure or recertification for additional licenses.

(e) Failure to comply with the requirements of this section shall constitute grounds for disciplinary action under each respective practice act and under s. 456.072(1)(k). In addition to discipline by the applicable board, the licensee shall be required to complete the course required under this section.

(2) Each applicable board may adopt rules to implement this section.

Section 3. This act shall take effect July 1, 2026.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 5, 2026

I respectfully request that **Senate Bill #844**, relating to Sickle Cell Disease Care Management and Treatment Continuing Education, 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)

Tab 4

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2/2/26
Meeting Date

Health Policy
Committee

SB 844
Bill Number or Topic

Amendment Barcode (if applicable)

Name Shamar Harper

Phone 954-665-5095

Address 3460 Foxcroft Rd 106
Street

Email

Miramar FL 33025
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

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2/2/26
Meeting Date

Health Policy
Committee

SB844
Bill Number or Topic

Amendment Barcode (if applicable)

Name Kemba Gosier

Phone 305-498-3533

Address 740 NW177 Terr
Street
Miami Gardens FL 33169
City State Zip

Email kgosier@asapbeinformed.org

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[X] 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)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

2/2/26
Meeting Date

Health Policy
Committee

SB 844
Bill Number or Topic

Amendment Barcode (if applicable)

Name Naashon Ducille

Phone 954-665-5095

Address 3460 Foxcroft Rd 106
Street

Email naashon.ducille@gmail.com

Miramar FL 33025
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[X] 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)

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The Florida Senate

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2/2/26
Meeting Date

Health Policy
Committee

SB 844
Bill Number or Topic

Amendment Barcode (if applicable)

Name Anthony Malcolm

Phone 954-655-4891

Address 4850 NW 12 Place
Street

Email THEVOICE305@yahoo.com

Lauderhill FL 33313
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

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Health Policy
Committee

SB844
Bill Number or Topic

Amendment Barcode (if applicable)

Name Kenley LaFrance

Phone 786-906-0235

Address 13890 NW 5Ct
Street

North Miami FLA 33168
City State Zip

Email OfficialKenleyLaFrance@gmail.com

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

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☐ I am a registered lobbyist, representing:

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The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 514
INTRODUCER:	Health Policy Committee and Senator Osgood
SUBJECT:	Doula Support for Healthy Births Pilot Program
DATE:	January 30, 2026 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 514 creates s. 383.295, F.S., and one non-statutory section of Florida law to, subject to a specific appropriation, establish the Doula Support for Health Births pilot program (pilot program) serving Broward, Miami-Dade, and Palm Beach counties and a corresponding Doula Certification Task Force (task force), respectively. Both the pilot program and the task force are to be run by the Department of Health (DOH).

The bill provides that the purpose of the pilot program is to improve birth outcomes by decreasing preterm birth rates and cesarean deliveries; enhancing access to care; and supporting maternal wellbeing throughout the pregnancy, labor, and postpartum periods using evidence-based methods. The pilot program is authorized to operate for 12 to 24 months, subject to funding, and the bill specifies the types of support services that must be offered under the pilot program. The DOH is authorized to integrate doula services into existing maternal and child health programs as an expansion of the pilot program as long as any expansion includes specified annual reporting requirements.

Set to run on a temporary basis in conjunction with the pilot program, the bill also creates the task force for the purpose of reviewing the scope of doula services and ensuring competency, quality, and consistency in the delivery of doula services to pregnant and postpartum women. The bill specifies the task force's membership and requires the task force to meet as often as necessary to complete its work, but at least quarterly. The bill also specifies the duties of the task

force and requires the task force to submit a final report to the Governor and the Legislature by January 1, 2028. The statutory authority for the task force expires October 2, 2029.

The provisions of the bill take effect upon becoming law.

II. Present Situation:

Doulas

The word "doula" was coined in the 1960s and comes from the Greek word meaning "women who serve." However, the role that doulas play—to provide company and support during pregnancy and birth—is one that has existed throughout American history, and in other cultures and traditions, for much longer.

Contemporary doulas are non-medical professionals who provide emotional, physical, and informational support and guidance in different aspects of reproductive health. Doulas can support someone through menstruation, fertility, pregnancy, abortion, miscarriage, labor and delivery, stillbirth, breastfeeding, postpartum care, and end of life care. Most doulas focus on prenatal care, labor and delivery, and postpartum care.

Doulas do not provide medical care and do not replace medical providers such as physicians, midwives, or nurses. Rather, doulas provide additional support in places and times where medical providers cannot or do not provide care, during the prenatal period, labor and delivery, and postpartum period. Community-based doulas typically come from the same community as the pregnant and postpartum people that they serve. This ensures cultural congruency, greater access to linguistic needs, and an understanding of the particular challenges faced by Black, Native American/ Indigenous, and other communities experiencing the highest burden of birth disparities.[1]

Currently, doula services can be covered as an optional expanded benefit under Florida's Medicaid managed care program. Many, but not all, Medicaid managed care plans offer coverage for doula services.[2]

Doula Training and Certification

While Florida does not require doulas to be licensed, one option for consumers who are looking to obtain doula services is to see if a doula is certified by one or more organizations. Organizations such as Lamaze, DONA, CAPPA, ToLABOR, and the Internation Childbirth Education Association (ICEA) provide training and certification to doulas. The types of certifications and training vary from organization to organization, but in general a doula can be certified to provide various types of childbirth education, labor and birthing services, postpartum care, and lactation services.

[1] What is a Doula?, National Health Law Program, available at https://healthlaw.org/wp-content/uploads/2020/04/WhatIsADoula_4.16.2020.pdf, (last visited Jan. 29, 2026).
[2] Statewide Medicaid Managed Care Update, July 10, 2028, Agency for Health Care Administration, available at https://ahca.myflorida.com/content/download/8890/file/SMMC_Update_7-2018.pdf?version=1, (last visited Jan. 29, 2026).

III. Effect of Proposed Changes:

Section 1 creates s. 383.295, F.S., to establish the Doula Support for Healthy Births pilot program. The bill defines the terms:

- "Department" to mean the DOH.
- "Doula" to mean a nonmedical professional who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum women before, during, and after childbirth, including support during miscarriage and stillbirth. Doulas are not clinical providers and are not licensed.
- "Doula services" to mean the provision of physical, emotional, and informational support by a nonmedical professional to a pregnant woman during the prenatal, intrapartum, and postpartum periods. Activities may include childbirth education, labor support, postpartum recovery support, assistance with infant care, lactation support, and connection to community resources.
- "Evidence-based" to mean a process in which decisions are made and actions or activities are carried out, based on the best evidence available, with the goal of removing subjective opinion, unfounded beliefs, or bias from decisions and actions. Such evidence may include practitioner experience and expertise as well as feedback from other practitioners and beneficiaries.

Subject to a specific appropriation in the General Appropriations Act, the bill creates the pilot program to serve Broward, Miami-Dade, and Palm Beach counties to integrate doula services into existing maternal health initiatives, targeting pregnant and postpartum women who have overcome or are overcoming substance use disorders. The purpose of the pilot program is to improve birth outcomes by decreasing preterm birth rates and cesarean deliveries, enhancing access to care, and supporting maternal well-being throughout the pregnancy, labor, and postpartum periods using evidence-based methods.

The bill requires the DOH, through its maternal and child health section, to implement and oversee the pilot program and specifies that the pilot program may operate for 12 to 24 months, subject to funding. The pilot program must offer the following services:

- Prenatal support, such as educational resources, personalized birth plans, and emotional support.
- Labor support, such as continuous emotional support, comfort measures, and communication facilitation.
- Postpartum support, such as assistance with newborn care, postpartum resources, and household tasks.
- Advocacy support, such as assistance with preferences and needs within medical settings and health care navigation.
- Comprehensive emotional support during the pregnancy and postpartum periods.

The bill requires the DOH to collaborate with health care providers, community organizations, community coalitions, and advocacy groups to integrate doulas and doula services into existing maternal health programs. Such doulas must be trained and:

- Demonstrate a strong understanding of the reproductive system, labor process, and postpartum recovery.
- Be proficient in hands-on techniques, such as massage, counterpressure, breathing exercises, and nonmedicated pain management.
- Support a client's birth plan, communicate effectively with medical staff, and advocate for informed consent.
- Provide guidance on breastfeeding, basic newborn care, and both the physical and emotional aspects of postpartum recovery.
- Use active listening, clear communication, and conflict resolution skills in interactions with clients and health care providers.
- Understand common medical complications and provide emotional and physical support to clients in challenging situations.
- Uphold professionalism, ethical decision making, and legal responsibilities in doula practice.

Additionally, the DOH must coordinate with local Women, Infants, and Children programs; hospitals; birth centers; and community health centers to facilitate outreach and service delivery.

The bill authorizes the DOH to integrate doula services into existing maternal and child health programs as an expansion of the pilot program, focusing on pregnant and postpartum women who have overcome or are overcoming substance use disorders. Any such expansion of the pilot program must include annual reporting requirements for the DOH to evaluate effectiveness, equity, and quality of integrating doula services into the existing maternal and child health programs.

Section 2 creates a new non-statutory section of law to establish the Doula Certification Task Force for the purpose of reviewing the scope of doula services and ensuring competency, quality, can consistency in the delivery of doula services to pregnant and postpartum women. The task force is created within the DOH and must be composed of nine members as follows:

- Three members appointed by the Governor;
- Three members appointed by the Senate President; and
- Three members appointed by the Speaker of the House of Representatives.

Of the nine members:

- Two members must be health care practitioners as defined in s. 456.001, F.S., experienced in caring for pregnant or postpartum women; and
- At least one member must be a doula or otherwise have experience providing nonmedical support services to pregnant or postpartum women.

The task force must elect a chair from among its members, and any vacancies must be filled in the same manner as the original appointment.

The task force is required to meet as often as necessary to complete its work, but at least quarterly, at the call of the chair and may conduct its meetings electronically. The task force is required to:

- Review the scope of practice for doulas in Florida, as well as in other states.
- Establish core competencies for the provision of doula services.
- Recommend minimum certification standards for doulas, which must include, but need not be limited to, all of the following:
  - Possession of a high school diploma or its equivalent.
  - Completion of a DOH-approved, evidence-based training program.
  - A minimum number of supervised practice hours.
  - Completion of a background screening.
  - Education in professional ethics.
- By January 1, 2028, submit a final report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The bill specifies that the task force operates on a temporary basis in conjunction with the pilot program and expires on October 2, 2029.

Section 3 provides that the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOH estimates a total annual cost of the pilot program to be $1,608,986.[3]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 383.295 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 February 2, 2026:
The CS removes the underlying bill's requirement that the pilot project be funded with Closing the Gap grant funds and instead makes the pilot project contingent on a specific appropriation in the General Appropriations Act.

B. Amendments:

None.

[3] Department of Health, *SB 514 Legislative Bill Analysis* (Nov. 20, 2025) (on file with Senate Committee on Health Policy).

199948

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2026	.	
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The Committee on Health Policy (Osgood) recommended the following:

Senate Amendment (with title amendment)

Delete lines 134 - 206

and insert:

(a) Subject to a specific appropriation of funds in the General Appropriations Act, the Doula Support for Healthy Births pilot program is established in Broward, Miami-Dade, and Palm Beach Counties to integrate doula services into existing maternal health initiatives, targeting pregnant and postpartum women who have overcome or are overcoming substance use

199948

disorders.

(b) The purpose of the pilot program is to improve birth outcomes by decreasing preterm birth rates and cesarean deliveries, enhancing access to care, and supporting maternal well-being throughout the pregnancy, labor, and postpartum periods using evidence-based methods.

(c) The department, through its maternal and child health section, shall implement and oversee the pilot program.

(3) PROGRAM STRUCTURE.—

(a) The pilot program may operate for 12 to 24 months, based on appropriated funds.

(b) The pilot program shall target the enrollment of pregnant and postpartum women who have overcome or are overcoming substance use disorders.

(c) The following support services must be offered under the pilot program:

1. Prenatal support, such as educational resources, personalized birth plans, and emotional support.

2. Labor support, such as continuous emotional support, comfort measures, and communication facilitation.

3. Postpartum support, such as assistance with newborn care, postpartum resources, and household tasks.

4. Advocacy support, such as assistance with preferences and needs within medical settings and health care navigation.

5. Comprehensive emotional support during the pregnancy and postpartum periods.

(4) COLLABORATION; INTEGRATION.—

(a) The department shall collaborate with:

1. Health care providers, community organizations,

199948

community coalitions, and advocacy groups to integrate doulas and doula services into existing maternal health programs, ensuring that such doulas are trained and meet all of the following criteria:

a. Demonstrate a strong understanding of the reproductive system, labor process, and postpartum recovery.

b. Are proficient in hands-on techniques, such as massage, counterpressure, breathing exercises, and nonmedicated pain management.

c. Support a client's birth plan, communicate effectively with medical staff, and advocate for informed consent.

d. Provide guidance on breastfeeding, basic newborn care, and both the physical and emotional aspects of postpartum recovery.

e. Use active listening, clear communication, and conflict resolution skills in interactions with clients and health care providers.

f. Understand common medical complications and provide emotional and physical support to clients in challenging situations.

g. Uphold professionalism, ethical decisionmaking, and legal responsibilities in doula practice.

2. Local WIC programs, hospitals, birth centers, and community health centers to facilitate outreach and service delivery.

(b) If appropriated funding is sufficient, the department may integrate doula services into existing maternal and child health programs as an expansion of the pilot program, focusing on pregnant and postpartum women who have overcome or are

199948

overcoming substance use disorders. Any such expansion of the pilot program must include annual reporting requirements for the department to evaluate effectiveness, equity, and quality of integrating doula services into the existing maternal and child health programs.

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

And the title is amended as follows:

Delete lines 6 - 21

and insert:

specified purpose, subject to a specific appropriation in the General Appropriations Act; providing the purpose of the pilot program; requiring the Department of Health, in collaboration with its maternal and child health section, to implement and oversee the pilot program; specifying the duration of the pilot program, based on appropriated funds; requiring the pilot program to target specified populations for enrollment; specifying services that must be provided under the pilot program; requiring the department to collaborate with specified entities to integrate doula services into existing maternal health programs and facilitate outreach and service delivery; authorizing the department to integrate doula services into existing maternal and child health programs as an expansion of the pilot program, subject to certain requirements; creating

By Senator Osgood

32-00380C-26 2026514__

A bill to be entitled

An act relating to the Doula Support for Healthy Births pilot program; creating s. 383.295, F.S.; defining terms; establishing the pilot program in Broward, Miami-Dade, and Palm Beach Counties for a specified purpose; providing the purpose of the pilot program; requiring the Department of Health, in collaboration with its maternal and child health section, to implement and oversee the pilot program; specifying the duration of the pilot program, subject to funding; requiring the pilot program to target specified populations for enrollment; specifying services that must be provided under the pilot program; requiring the department to collaborate with specified entities to integrate doula services into existing maternal health programs and facilitate outreach and service delivery; authorizing the department to integrate doula services into existing maternal and child health programs as an expansion of the pilot program, subject to certain requirements; providing for funding of the pilot program; creating the Doula Certification Task Force within the department for a specified purpose; requiring the department to oversee and provide administrative support to the task force; providing for membership and meetings of the task force; specifying duties of the task force; requiring the task force to submit a final report of its findings and recommendations to the Governor and the Legislature by a specified date;

providing for expiration of the task force; providing an effective date.

WHEREAS, preterm birth is defined as a live birth before 37 completed weeks of gestation and is associated with increased morbidities or ailments, such as cerebral palsy, breathing difficulties, feeding problems, developmental delay, and vision and hearing problems, and

WHEREAS, preterm labor occurs when regular contractions cause the cervix to open between 20 and 37 weeks of gestation, which can result in a baby being born before 37 weeks of gestation, and the earlier the delivery, the greater the health risks for the baby, requiring special care in a neonatal intensive care unit and potentially causing long-term mental and physical health concerns, and

WHEREAS, Florida's preterm birth rate has risen annually since 2014 to its current average rate of 10.9 percent, higher than the national average of 10.5 percent, and

WHEREAS, Florida ranks among the highest in the nation for infant mortality, with a rate of 5.9 deaths per 1,000 births, higher than the national average of 5.4 deaths per 1,000 births, and

WHEREAS, Florida also has one of the highest cesarean delivery rates in the nation at 37.4 percent, compared to the national average of 31.8 percent, with cesarean delivery being associated with increased risks to infants, including respiratory distress, infection, and long-term health complications, and

WHEREAS, maternal mortality is defined as the annual number

of female deaths from any cause related to or aggravated by pregnancy or its management, excluding accidental or incidental causes, during pregnancy and childbirth or within 42 days after termination of a pregnancy, irrespective of the duration and site of the pregnancy, and

WHEREAS, Florida ranks 17th in the nation with a maternal mortality rate of 26.3 deaths per 100,000 births, compared to a national rate of 23.2 deaths per 100,000 births, and

WHEREAS, Broward County has a maternal mortality rate of 24.8 deaths per 100,000 live births, and an infant mortality rate of 5 deaths per 1,000 live births, and

WHEREAS, Miami-Dade County has a maternal mortality rate of 20.3 deaths per 100,000 live births, and an infant mortality rate of 4.8 deaths per 1,000 live births, and

WHEREAS, Palm Beach County has a maternal mortality rate of 33.2 deaths per 100,000 live births, and an infant mortality rate of 5.4 deaths per 1,000 live births, and

WHEREAS, continued perinatal support, including the services provided by trained doulas, is associated with reduced rates of cesarean delivery and improved birth outcomes, and

WHEREAS, Florida has ongoing challenges related to child safety and welfare, with statistics showing disparities in health and safety outcomes for children across racial and socioeconomic groups, and

WHEREAS, doula care is the continuous, one-to-one emotional, informational, and physical support provided by a trained nonmedical professional to pregnant women and their families during pregnancy, labor, and the postpartum period, and

WHEREAS, while doulas do not perform medical tasks, they

provide an array of educational and support services throughout the birthing process to ensure that the mother has a positive and empowering experience, including, but not limited to, educational resources and information about pregnancy, childbirth, and postpartum care; assistance in creating a birth plan; continuous emotional support during labor and delivery; assistance with breathing techniques, relaxation, and positioning during labor; massage and counterpressure measures; facilitation of communication with medical staff; advocacy in and navigation of the medical setting; and postpartum support with newborn care and feeding, and

WHEREAS, evidence-based support provided by trained doulas has been shown to enhance birth experiences, reduce cesarean deliveries, and improve overall health outcomes for mothers and infants, and

WHEREAS, the state has a compelling interest in improving maternal and infant outcomes through increased access to high-quality doula services, NOW, THEREFORE,

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

Section 1. Section 383.295, Florida Statutes, is created to read:

383.295 Doulas.—

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

(a) "Department" means the Department of Health.

(b) "Doula" means a nonmedical professional who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum women before,

during, and after childbirth, including support during miscarriage and stillbirth. Doulas are not clinical providers and are not licensed.

(c) "Doula services" means the provision of physical, emotional, and informational support by a nonmedical professional to a pregnant woman during the prenatal, intrapartum, and postpartum periods. Activities may include childbirth education, labor support, postpartum recovery support, assistance with infant care, lactation support, and connection to community resources.

(d) "Evidence-based" means a process in which decisions are made and actions or activities are carried out, based on the best evidence available, with the goal of removing subjective opinion, unfounded beliefs, or bias from decisions and actions. Such evidence may include practitioner experience and expertise as well as feedback from other practitioners and beneficiaries.

(2) PILOT PROGRAM ESTABLISHED.—

(a) The Doula Support for Healthy Births pilot program is established in Broward, Miami-Dade, and Palm Beach Counties to integrate doula services into existing maternal health initiatives, targeting pregnant and postpartum women who have overcome or are overcoming substance use disorders.

(b) The purpose of the pilot program is to improve birth outcomes by decreasing preterm birth rates and cesarean deliveries, enhancing access to care, and supporting maternal well-being throughout the pregnancy, labor, and postpartum periods using evidence-based methods.

(c) The Department of Health, through its maternal and child health section, shall implement and oversee the pilot

program.

(3) PROGRAM STRUCTURE.—

(a) The pilot program may operate for 12 to 24 months, subject to funding.

(b) The pilot program shall target the enrollment of pregnant and postpartum women who have overcome or are overcoming substance use disorders.

(c) The following support services must be offered under the pilot program:

1. Prenatal support, such as educational resources, personalized birth plans, and emotional support.

2. Labor support, such as continuous emotional support, comfort measures, and communication facilitation.

3. Postpartum support, such as assistance with newborn care, postpartum resources, and household tasks.

4. Advocacy support, such as assistance with preferences and needs within medical settings and health care navigation.

5. Comprehensive emotional support during the pregnancy and postpartum periods.

(4) COLLABORATION; INTEGRATION.—

(a) The department shall collaborate with:

1. Health care providers, community organizations, community coalitions, and advocacy groups to integrate doulas and doula services into existing maternal health programs, ensuring that such doulas are trained and meet all of the following criteria:

a. Demonstrate a strong understanding of the reproductive system, labor process, and postpartum recovery.

b. Are proficient in hands-on techniques, such as massage,

counterpressure, breathing exercises, and nonmedicated pain management.

c. Support a client's birth plan, communicate effectively with medical staff, and advocate for informed consent.

d. Provide guidance on breastfeeding, basic newborn care, and both the physical and emotional aspects of postpartum recovery.

e. Use active listening, clear communication, and conflict resolution skills in interactions with clients and health care providers.

f. Understand common medical complications and provide emotional and physical support to clients in challenging situations.

g. Uphold professionalism, ethical decisionmaking, and legal responsibilities in doula practice.

2. Local WIC programs, hospitals, birth centers, and community health centers to facilitate outreach and service delivery.

(b) The department may integrate doula services into existing maternal and child health programs as an expansion of the pilot program, focusing on pregnant and postpartum women who have overcome or are overcoming substance use disorders. Any such expansion of the pilot program must include annual reporting requirements for the department to evaluate effectiveness, equity, and quality of integrating doula services into the existing maternal and child health programs.

(5) FUNDING.—The pilot program shall be funded using appropriations for the Closing the Gap grant program established under ss. 381.7351-381.7356. The department shall coordinate

with its Division of Community Health Promotion and Office of Minority Health and Health Equity to seek additional federal funds to support implementation.

Section 2. Doula Certification Task Force.—

(1) ESTABLISHMENT.—There is created within the Department of Health the Doula Certification Task Force, a task force as defined in s. 20.03(5), Florida Statutes, for the purpose of reviewing the scope of doula services and ensuring competency, quality, and consistency in the delivery of doula services to pregnant and postpartum women.

(2) OVERSIGHT.—The Department of Health shall oversee and provide administrative support to the task force.

(3) MEMBERSHIP; MEETINGS.—

(a) The task force shall be composed of nine members. Three members shall be appointed by the Governor, three members shall be appointed by the Senate President, and three members shall be appointed by the Speaker of the House of Representatives. Of the nine members, two members must be health care practitioners as defined in s. 456.001, Florida Statutes, experienced in caring for pregnant or postpartum women, and at least one member must be a doula or otherwise have experience providing nonmedical support services to pregnant or postpartum women. A vacancy on the task force must be filled in the same manner as the original appointment. The task force shall elect a chair from among its members.

(b) The task force shall meet as often as necessary to complete its work, but at least quarterly, at the call of the chair. The task force may conduct its meetings through teleconference or other similar electronic means.

(4) DUTIES.—The task force shall do all of the following:

(a) Review the scope of practice for doulas in this state, as well as in other states.

(b) Establish core competencies for the provision of doula services.

(c) Recommend minimum certification standards for doulas, which must include, but need not be limited to, all of the following:

1. Possession of a high school diploma or its equivalent.

2. Completion of a department-approved, evidence-based training program.

3. A minimum number of supervised practice hours.

4. Completion of a background screening.

5. Education in professional ethics.

(5) REPORT.—By January 1, 2028, the task force shall submit a final report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(6) SUNSET.—The task force shall operate on a temporary basis in conjunction with the Doula Support for Healthy Births pilot program established under s. 383.295, Florida Statutes, as created by this act, and shall expire on October 2, 2029, in accordance with s. 20.052(8), Florida Statutes.

Section 3. This act shall take effect upon becoming a law.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 3, 2026

I respectfully request that **Senate Bill #514**, relating to Doula Support for Healthy Births Pilot Program, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Rosalind Osgood

Senator Rosalind Osgood
Florida Senate, District 32

File signed original with committee office

S-020 (03/2004)

Tab 5

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2/2/2026
Meeting Date

Health Policy
Committee

574
Bill Number or Topic

Amendment Barcode (if applicable)

Name Melanie Andrade Williams

Phone

Address
Street

Email williams@floridahealthjustice.org

Tallahassee FL 32312
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Health Justice Project

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

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The Florida Senate

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Senate professional staff conducting the meeting

February 2, 2026
Meeting Date

Sen. Health Policy
Committee

SB 514
Bill Number or Topic

Amendment Barcode (if applicable)

Name Cathy Timuta - Florida Association of Healthy Start Coalitions

Phone 850.999.6200

Address 2002 Old St. Augustine Road, Suite E-45
Street

Email ctimuta@fahsc.org

Tallahassee FL 32301
City *State* *Zip*

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

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☐ 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

2-3-26
Meeting Date

Health Policy
Committee

514
Bill Number or Topic

Amendment Barcode (if applicable)

Name Barbara DeVane

Phone 850-251-4280

Address 625 E. Brevard St
Street

Tallahassee FL 32308
City State Zip

Email barbradevane1@yahoo.com

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: FL NOW

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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2/2/26
Meeting Date

Health Policy
Committee

514
Bill Number or Topic

Amendment Barcode (if applicable)

Name Karen Woodall

Phone 850-321-9386

Address 529 E. Call
Street

Email fcfep@yahoo.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: National Latina Advocacy Institute for Reproductive ~~Health~~ Justice

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

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S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1404
INTRODUCER:	Health Policy Committee and Senator Burton
SUBJECT:	Memory Care
DATE:	February 4, 2026
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1404 amends, creates, and repeals several sections of the Florida Statutes to create a new assisted living facility (ALF or facility) specialty license type for "memory care services." The bill requires an ALF, under certain conditions, to obtain a memory care services license, within a specified timeframe, to provide memory care services, serve memory care residents, or advertise or hold itself out to provide such services or serve such residents.

The bill defines the terms "memory care resident" and "memory care services" and requires the Agency for Health Care Administration (AHCA) to adopt rules by October 1, 2026, establishing minimum standards for memory care services licenses and providing criteria for what such standards must address. Additionally, the bill provides criteria for how a memory care resident may choose to stay at an ALF should the ALF not be able to obtain a memory care services license.

The bill also creates s. 430.71, F.S., to establish the Florida Alzheimer's Center of Excellence (Center) to assist and support persons with Alzheimer's disease and related forms of dementia (ADRD) and their caregivers by connecting them with resources in their communities to allow them to age in place and to empower family caregivers to improve their own wellbeing. The bill creates the Center within the Department of Elderly Affairs (DOEA) and tasks the Center with specified activities related to its stated goals. Additionally, the bill establishes eligibility criteria for a person to qualify for services through the Center and requires the Center to submit an

annual report to the Governor and the Legislature with specific data related to the services provided by the Center.

Lastly, effective upon the date when the AHCA's rules implementing memory care services licenses take effect, the bill repeals ss. 429.178 and 429.177, F.S.

The bill takes effect upon becoming law.

II. Present Situation:

Alzheimer's Disease and Related Dementias

ADRD are debilitating conditions that impair memory, thought processes, and functioning, primarily among older adults. The effects of these diseases can be devastating, both for individuals afflicted with ADRD and for their families. People with ADRD may require significant amounts of health care and intensive long-term services and supports – including, but not limited to, management of chronic conditions, help taking medications, round-the-clock supervision and care, or assistance with personal care activities, such as eating, bathing, and dressing. In the United States, ADRD affects as many as five million people and nearly 40 percent of the population aged 85 and older. Roughly 13.2 million older Americans are projected to have ADRD by 2050.[1]

Assisted Living Facilities

An ALF is a residential facility, or part of a residential facility, which provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[2] According to the Agency for Health Care Administration (AHCA), an ALF is designed to provide personal care services in the least restrictive and most home-like environment.[3] ALFs can range in size from one resident to several hundred and may offer a wide variety of personal and nursing services designed specifically to meet an individual's personal needs.[4]

Facilities are licensed to provide routine personal care services under a standard license, or more specific services under the authority of specialty licenses. The purpose of specialty licenses is to allow individuals to age in place[5] in familiar surroundings that can adequately and safely meet their continuing health care needs.[6] In addition to a standard license, an ALF can also be licensed

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[1] What is Alzheimer's Disease and Related Dementias, U.S. Department of Health and Human Services, available at https://aspe.hhs.gov/collaborations-committees-advisory-groups/napa/what-ad-adrd, (last visited Jan 28, 2026).
[2] Section 429.02(5), F.S.
[3] Assisted Living Facility, Florida Agency for Health Care Administration, available at http://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/assisted-living-unit/assisted-living-facility, (last visited Jan. 27, 2026).
[4] *Id*.
[5] Section 429.02(4), F.S., defines "aging in place" as the process of providing increased or adjusted services to a person to compensate for the physical or mental decline that may occur with the aging process, in order to maximize the person's dignity and independence and permit them to remain in a familiar, noninstitutional, residential environment for as long as possible. Such services may be provided by facility staff, volunteers, family, or friends, or through contractual arrangements with a third party.
[6] *Supra* n. 2.

to provide one or more of extended congregate care (ECC), limited nursing services (LNS), or limited mental health (LMH) services.[7] Currently there are 2,989 licensed ALFs in Florida with 171 licensed to provide ECC, 396 licensed to provide LNS, and 703 licensed to provide LMH services.[8]

Extended Congregate Care

The purpose of an ECC license is to allow an ALF to provides services, directly or through contract, beyond those allowed by a standard ALF license, including nursing and supportive services, to persons who would otherwise be disqualified from continued residence in a standard licensed facility.[9] An ALF with an ECC license is exempt from criteria for continued residency established for standard ALFs[10] and may establish its own guidelines for continued residency as long as such guidelines meet the criteria for ECC policies in Rule 59A-36.021, F.A.C.[11] Additionally, ECC facilities are prohibited from serving residents who require 24-hour nursing supervision.[12]

Limited Nursing Services

A LNS license authorizes an ALF to provide nursing services[13] to a resident such as the care of routine dressings and care of casts, braces, and splints.[14] A LNS license does not exempt the facility from meeting admission and continued residency criteria for a standard ALF license unless the facility is also licensed to provide ECC. Additionally, a LNS license does not authorize the provision of 24-hour nursing care.[15]

Limited Mental Health

An ALF that serves one or more mental health residents is required to obtain a LMH license. A mental health resident is an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.[16] A facility with a LMH license is required to:

- Ensure that, within six months after receiving the LMH license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than six hours related to their duties.
- Provide appropriate supervision and staffing to provide for the health, safety, and welfare of its mental health residents.

[7] Section 429.07(3), F.S.
[8] Florida Health Finder Report, available at https://quality.healthfinder.fl.gov/Facility-Provider/ALF?&type=1, (last visited Jan. 27, 2026).
[9] Section 429.07(3)(b), F.S.
[10] Rule 59A-36.006(4), F.A.C.
[11] Section 429.07(3)(b)5, F.S.
[12] *Id*.
[13] Services authorized to be provided by someone licensed under Part I of ch. 464, F.S.
[14] Section 429.02(14), F.S.
[15] *Id*.
[16] Section 429.02(16), F.S.

- Have a copy of each mental health resident's community living support plan[17] and the cooperative agreement[18] with the mental health care services provider or provide written evidence that a request for the community living support plan and the cooperative agreement was sent to the resident's Medicaid managed care plan or the appropriate managing entity under contract with the Department of Children and Families (DCF) within 72 hours after admission. The support plan and the agreement may be combined.
- Have documentation provided by the DCF that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission.
- Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document.
- Assist the mental health resident in carrying out the activities identified in the resident's community living support plan.[19]

Memory Care in Assisted Living Facilities in Florida

Although many Florida ALFs claim to be memory care facilities or advertise as providing specialized care for persons with ADRD, there is currently no licensure category specific to memory care and very few regulations in either law or rule for providing such care. Rules that do exist require an ALF that claims to provide special care for persons with ADRD to:

- Disclose in its advertisements or in a separate document those services that distinguish the care as being especially able to, or suitable for, such persons. The facility must give a copy of all such advertisements or documents to any person who requests them and must maintain a copy of each in its records. The AHCA is required to examine all such advertisements and documents as part of the facility's license renewal procedure;[20]
- Have an awake staff member on duty at all hours of the day and night, or, if the facility has fewer than 17 residents, have mechanisms in place to monitor and ensure the safety of the facility's residents; [21]
- Offer activities specifically designed for persons who are cognitively impaired;[22]

[17] Section 429.02(8), F.S., defines "community living support plan" as a written document prepared by a mental health resident and the resident's mental health case manager in consultation with the administrator of an assisted living facility with a limited mental health license or the administrator's designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs of the resident which enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services.
[18] Section 429.02(9), F.S., defines "cooperative agreement" to mean a written statement of understanding between a mental health care provider and the administrator of the assisted living facility with a limited mental health license in which a mental health resident is living. The agreement must specify directions for accessing emergency and after-hours care for the mental health resident. A single cooperative agreement may service all mental health residents who are clients of the same mental health care provider.
[19] Section 429.075, F.S.
[20] Section 429.177, F.S.
[21] Section 429.178, F.S.
[22] *Id*.

- Have a physical environment that provides for the safety and welfare of the facility's residents;[23] and
- Employ staff who must complete the training and continuing education required under s. 430.5025, F.S., that includes:
  - Within three months after beginning employment, each employee who provides personal care to, or has regular contact with, residents with ADRD complete an additional three hours of training as specified.
  - Within six months after beginning employment, each employee who provides personal care must complete an additional four hours of dementia-specific training. Such training must include, but is not limited to, understanding ADRD, the stages of Alzheimer's disease, communication strategies, medical information, and stress management.
  - Thereafter, each employee who provides personal care must participate in at least four hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning technology.

While the existing law and rules provide some minimum requirements, there is little specificity as to how those requirements must be implemented. This lack of specificity largely leaves the decisions on how to implement those requirements up to each individual ALF. As such, the type and quality of care a resident may receive from one memory care ALF to another may vary widely.

III. Effect of Proposed Changes:

Sections 1 through 3 amend ss. 429.02 and 429.07, F.S., and create s. 429.076, F.S., to establish a new specialty ALF license type for "memory care services." The bill defines the terms:

- "Memory care resident" to mean a person who suffers from ADRD who is a resident of an ALF that claims or otherwise represents that it provides specialized care, services, or activities specifically to support such resident's ADRD, irrespective of whether such care, services, or activities were listed in the resident's contract; and
- "Memory care services" to mean specific specialized or focused care, services, or activities an ALF agrees to provide to a memory care resident to support his or her ADRD. Such services do not include services, care, or activities provided by the ALF as optional supportive services that are available to all residents of the facility.

The bill requires an ALF to obtain a memory care services license if the ALF serves one or more memory care residents or advertises or otherwise holds itself out as providing memory care services. However, the bill specifies that an ALF is not required to obtain a memory care services license if the facility solely provides optional supportive services[24] for residents with ADRD which are available to all residents of the facility so long as the facility complies with rules the bill requires the AHCA to adopt on advertising.

The bill requires the AHCA to adopt rules for minimum standards for memory care services licenses by October 1, 2026, and specifies that such rules must include, but are not limited to:

[23] *Supra* n. 22.

[24] Section 429.02(27), F.S., defines "supportive services" as services designed to encourage and assist aged persons or adults with disabilities to remain in the least restrictive living environment and to maintain their independence as long as possible.

- Policies and procedures for providing memory care services.
- Standardized admittance criteria for memory care residents.
- The minimum level of care, services, and activities that must be provided to memory care residents.
- Minimum training requirements for staff at a facility with a memory care services license, which must meet or exceed training requirements established in s. 430.5025, F.S.
- Safety requirements specific to memory care residents, including, but not limited to, requiring a memory care services licensee to maintain at least one awake staff member to be on duty at all hours.
- Physical plant requirements for a facility, or parts of a facility as specified by the licensee, serving memory care residents.
- Requirements for contracts with memory care residents which, in addition to the requirements established by s. 429.24, F.S., must require a memory care services licensee to specify the memory care services that will be provided to the memory care resident.
- Reasonable limitations on how an assisted living facility may advertise or hold itself out as providing optional supportive services for residents with Alzheimer's disease and related dementias without obtaining a memory care services license.

An ALF that is licensed on or after the effective date of the AHCA's rules must obtain a memory care services license to provide memory care services, serve memory care residents, or advertise or hold itself out as providing memory care services or otherwise serving memory care residents. If the facility was licensed prior to the effective date of the rules, it must obtain a memory care services license upon licensure renewal in order to start or continue to provide such services or serve such residents.

Lastly, the bill provides that if an ALF serves one or more memory care residents who were accepted before the effective date AHCA's rules, that ALF may continue to serve those residents without obtaining a memory care services license if the ALF:

- Demonstrates to the AHCA that it is unable to reasonably obtain such license;
- Notifies any memory care residents the facility serves and their caregivers, if applicable, that:
  - The facility is required to obtain a memory care services license;
  - The facility is unable to obtain such license; and
  - The memory care resident may relocate to a facility with a memory care services license, if desired.
- Upon request, assists memory care residents or, if applicable, their caregivers with finding a suitable alternate facility.
- No longer accepts any new memory care residents without first obtaining a memory care services license.

Should a resident, or his or her caregiver if applicable, decide to remain at a facility under these conditions, the facility must:

- Amend the resident's contract to include the memory care services that are being provided to the resident;
- Maintain records pertaining to when and how such services were provided to the resident; and
- Provide such records to the resident, his or her caregivers, or the AHCA upon request.

Section 4 creates s. 430.71, F.S., to establish the Florida Alzheimer's Center of Excellence within the DOEA. The bill provides that the purpose of the Center is to assist and support persons with ADRD and their caregivers by connecting them with resources in their communities to address the following goals:

- To allow residents of this state living with ADRD to age in place.
- To empower family caregivers to improve their own wellbeing.

The bill allows the Center to contract for services necessary to implement its goals and requires the Center to:

- Conduct caregiver assessments to measure caregiver burden.
- Create personalized plans that guide caregivers to community resources, empowering them with the skills, education, support, and planning necessary for effective caregiving, including addressing any medical, emotional, social, legal, or financial challenges experienced by the person with ADRD.
- Educate and assist caregivers with strategies for caregiving for someone with ADRD and provide guidance on all aspects of home-based care, including home safety, physical and mental health, legal and financial preparedness, communication skills, and hands-on care techniques.
- Provide online educational resources for caregivers.
- Track outcomes, including, but not limited to, decreased hospitalizations, reduced emergency department visits, reduction in falls, and reduction in caregiver burnout.
- By December 1 of each year, submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which addresses the number of families served, the types of services provided, and the outcomes achieved.

The bill requires the Center to work with:

- Area agencies on aging as defined in s. 430.203, F.S.;
- The Alzheimer's Disease Advisory Committee established under s. 430.501, F.S.;
- The Alzheimer's Disease Initiative established under ss. 430.501-430.504, F.S.;
- The state-funded memory disorder clinics established under s. 430.502, F.S.;
- The DOEA's Dementia Care and Cure Initiative task forces;
- Universities;
- Hospitals; and
- Other available community resources to ensure full use of the state's infrastructure.

In order to qualify for services from the Center, an individual or caregiver must:

- Live in a household where at least one person is a caregiver for a person diagnosed or suspected to have ADRD and either the caregiver or the person diagnosed or suspected to have ADRD is a resident of Florida.
- Have the goal of providing in-home care for the person diagnosed with or suspected to have ADRD.

Should a person be eligible, the Center is authorized to provide assistance to the caregiving family, subject to the availability of funds and resources.

Section 5 repeals ss. 429.177 and 429.178, F.S., effective upon the adoption of rules establishing minimum standards for memory care services licenses.

Section 6 provides that the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may have an indeterminate negative fiscal impact on those ALFs that are required to meet additional criteria to obtain a memory care services license.

C. Government Sector Impact:

The bill may have an indeterminate negative fiscal impact on the AHCA due to the requirement to adopt rules and administer the new memory care services license type.

The bill may have an indeterminate negative fiscal impact on the DOEA related to establishing the Center.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 429.02 and 429.07 of the Florida Statutes.

This bill creates sections 429.076 and 430.71 of the Florida Statutes.

This bill repeals sections 429.177 and 429.178 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 February 2, 2026:

The CS:

- Replaces current memory care provisions in the bill and creates a new "memory care services" specialty license type which an ALF may obtain in addition to the standard ALF license.
- Defines terms and requires an ALF to obtain a memory care services license under certain circumstances.
- Requires the AHCA to adopt rules for minimum standards to obtain and maintain a memory care services license.
- Provides a timeline for ALFs to obtain a memory care services license.
- Provides flexibility for ALF residents who need memory care services to choose to stay at an ALF even if the ALF would be required to obtain a memory care services license under certain circumstances.
- Effective upon the adoption of AHCA's rules for memory care services licenses, repeals ss. 429.177 and 429.178, F.S.
- Changes the effective date of the bill to effective upon becoming law.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Burton) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Present subsections (15) through (28) of section 429.02, Florida Statutes, are redesignated as subsections (17) through (30), respectively, new subsections (15) and (16) are added to that section, and subsection (12) of that section is amended, to read:

429.02 Definitions.—When used in this part, the term:

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(12) "Extended congregate care" means acts beyond those authorized in subsection (20) ~~(18)~~ which may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services that may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(15) "Memory care resident" means a person who suffers from Alzheimer's disease or a related dementia who is a resident of an assisted living facility that claims or otherwise represents that it provides specialized care, services, or activities specifically to support such resident's Alzheimer's disease or related dementia, irrespective of whether such care, services, or activities were listed in the resident's contract.

(16) "Memory care services" means specific specialized or focused care, services, or activities an assisted living facility agrees to provide to a memory care resident to support his or her Alzheimer's disease or related dementia. Such services do not include services, care, or activities provided by the assisted living facility as optional supportive services that are available to all residents of the facility.

Section 2. Subsection (3) of section 429.07, Florida Statutes, is amended to read:

429.07 License required; fee.—

(3) In addition to the requirements of s. 408.806, each license granted by the agency must state the type of care for which the license is granted. Licenses shall be issued for one

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or more of the following categories of care: standard, extended congregate care, limited nursing services, ~~or~~ limited mental health, or memory care services.

(a) A standard license shall be issued to facilities providing one or more of the personal services identified in s. 429.02. Such facilities may also employ or contract with a person licensed under part I of chapter 464 to administer medications and perform other tasks as specified in s. 429.255.

(b) An extended congregate care license shall be issued to each facility that has been licensed as an assisted living facility for 2 or more years and that provides services, directly or through contract, beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part. An extended congregate care license may be issued to a facility that has a provisional extended congregate care license and meets the requirements for licensure under subparagraph 2. The primary purpose of extended congregate care services is to allow residents the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired. A facility licensed to provide extended congregate care services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if he or she is determined appropriate for admission to the extended congregate care facility.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements

established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of the facility. This designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Each existing facility that qualifies to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved by the agency;

d. Violation of resident care standards which results in requiring the facility to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility licensed under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium pursuant to this part or part

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II of chapter 408 or initiation of injunctive proceedings.

The agency may deny or revoke a facility's extended congregate care license for not meeting the criteria for an extended congregate care license as provided in this subparagraph.

2. If an assisted living facility has been licensed for less than 2 years, the initial extended congregate care license must be provisional and may not exceed 6 months. The licensee shall notify the agency, in writing, when it has admitted at least one extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with the requirements of an extended congregate care license. A licensee with a provisional extended congregate care license which demonstrates compliance with all the requirements of an extended congregate care license during the inspection shall be issued an extended congregate care license. In addition to sanctions authorized under this part, if violations are found during the inspection and the licensee fails to demonstrate compliance with all assisted living facility requirements during a follow-up ~~followup~~ inspection, the licensee shall immediately suspend extended congregate care services, and the provisional extended congregate care license expires. The agency may extend the provisional license for not more than 1 month in order to complete a follow-up ~~followup~~ visit.

3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general

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status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has:

a. Held an extended congregate care license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

4. A facility that is licensed to provide extended congregate care services must:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency.

d. Adopt and follow policies and procedures that maximize

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resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.

h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.

5. A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour nursing supervision. A licensed facility that provides extended congregate care services must also provide each resident with a written copy of facility policies governing admission and retention.

6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(5) and the facility must develop a preliminary service plan for the individual.

7. If a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility must make arrangements for relocating the person in accordance with s. 429.28(1)(k).

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. This designation may be made at the time of initial licensure or licensure renewal, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies to provide limited nursing services must have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the

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agency shall visit the facility at least annually to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility. Visits may be in conjunction with other agency inspections. The agency may waive the required yearly monitoring visit for a facility that has:

a. Had a limited nursing services license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services.

Section 3. Section 429.076, Florida Statutes, is created to read:

429.076 Memory care services license.—An assisted living facility that serves one or more memory care residents, or that advertises or otherwise holds itself out as providing memory care services, must obtain a memory care services license

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pursuant to subsection (3) or subsection (4), as applicable. A facility is not required to obtain a memory care services license if the facility solely provides optional supportive services for residents with Alzheimer's disease and related dementias which are available to all residents of the facility so long as the facility complies with agency rules on advertising pursuant to paragraph (2)(h).

(1) To obtain a memory care services license, an assisted living facility must maintain a standard assisted living facility license and meet any additional minimum requirements adopted by rule.

(2) By October 1, 2026, the agency shall adopt rules to provide minimum standards for memory care services licenses. Such rules must include, but are not limited to:

(a) Policies and procedures for providing memory care services.

(b) Standardized admittance criteria for memory care residents.

(c) The minimum level of care, services, and activities that must be provided to memory care residents.

(d) Minimum training requirements for staff at a facility with a memory care services license, which must meet or exceed training requirements established in s. 430.5025.

(e) Safety requirements specific to memory care residents, including, but not limited to, requiring a memory care services licensee to maintain at least one awake staff member to be on duty at all hours.

(f) Physical plant requirements for a facility, or parts of a facility as specified by the licensee, serving memory care

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residents.

(g) Requirements for contracts with memory care residents which, in addition to the requirements established by s. 429.24, must require a memory care services licensee to specify the memory care services that will be provided to the memory care resident.

(h) Reasonable limitations on how an assisted living facility may advertise or hold itself out as providing optional supportive services for residents with Alzheimer's disease and related dementias without obtaining a memory care services license.

(3) An assisted living facility licensed on or after the effective date of the rules required by subsection (2) must obtain a memory care services license to provide memory care services, serve memory care residents, or advertise or hold itself out as providing memory care services or otherwise serving memory care residents.

(4) Except as provided in subsection (5), an assisted living facility licensed before the effective date of the rules required by subsection (2) must obtain a memory care services license when such facility renews its license in order to begin or continue to provide memory care services, serve memory care residents, or advertise or hold itself out as providing such services or serving such residents.

(5)(a) A facility that serves one or more memory care residents accepted before the effective date of the rules required by subsection (2) may continue to serve such memory care residents and provide memory care services to such residents without obtaining a memory care services license if

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the facility:

1. Demonstrates to the agency that it is unable to reasonably obtain such license;

2. Notifies any memory care residents the facility serves and their caregivers, if applicable, that:

a. The facility is required to obtain a memory care services license;

b. The facility is unable to obtain such license; and

c. The memory care resident may relocate to a facility with a memory care services license, if desired.

3. Upon request, assists memory care residents or, if applicable, their caregivers with finding a suitable alternate facility.

4. No longer accepts any new memory care residents without first obtaining a memory care services license.

(b) If, after receiving the notice required by subparagraph (a)2., a memory care resident or, if applicable, his or her caregiver decides that the resident will remain at the facility, the facility must:

1. Amend the resident's contract to include the memory care services that are being provided to the resident;

2. Maintain records pertaining to when and how such services were provided to the resident; and

3. Provide such records to the resident, his or her caregivers, or the agency upon request.

Section 4. Section 430.71, Florida Statutes, is created to read:

430.71 Florida Alzheimer's Center of Excellence.—

(1) PURPOSE AND INTENT.—The purpose of this section is to

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assist and support persons with Alzheimer's disease or related dementias and their caregivers by connecting them with resources in their communities to address the following goals:

(a) To allow residents of this state living with Alzheimer's disease or related dementias to age in place.

(b) To empower family caregivers to improve their own well-being.

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

(a) "Center" means the Florida Alzheimer's Center of Excellence.

(b) "Department" means the Department of Elderly Affairs.

(3) POWERS AND DUTIES.—

(a) There is created within the department the Florida Alzheimer's Center of Excellence, which shall assist in improving the quality of care for persons living with Alzheimer's disease and related dementias and improving the quality of life for family caregivers. The center may contract for services necessary to implement this section. The center shall do all of the following:

1. Conduct caregiver assessments to measure caregiver burden.

2. Create personalized plans that guide caregivers to community resources, empowering them with the skills, education, support, and planning necessary for effective caregiving, including addressing any medical, emotional, social, legal, or financial challenges experienced by the person with Alzheimer's disease or a related dementia.

3. Educate and assist caregivers with strategies for caregiving for someone with Alzheimer's disease or a related

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dementia and provide guidance on all aspects of home-based care, including home safety, physical and mental health, legal and financial preparedness, communication skills, and hands-on care techniques.

4. Provide online educational resources for caregivers.

5. Track outcomes, including, but not limited to, decreased hospitalizations, reduced emergency department visits, reduction in falls, and reduction in caregiver burnout.

6. By December 1 of each year, submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which addresses the number of families served, the types of services provided, and the outcomes achieved.

(b) The center shall work with area agencies on aging as defined in s. 430.203; the Alzheimer's Disease Advisory Committee established under s. 430.501; the Alzheimer's Disease Initiative established under ss. 430.501-430.504; the state-funded memory disorder clinics established under s. 430.502; the department's Dementia Care and Cure Initiative task forces; universities; hospitals; and other available community resources to ensure full use of the state's infrastructure.

(4) ELIGIBILITY FOR SERVICES.—

(a) To qualify for assistance from the center, an individual or a caregiver must meet all of the following criteria:

1. At least one person in the household is a caregiver for a person diagnosed with, or suspected to have, Alzheimer's disease or a related dementia.

2. The caregiver or the person diagnosed with, or suspected

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to have, Alzheimer's disease or a related dementia is a resident of this state.

3. The person seeking assistance has the goal of providing in-home care for the person diagnosed with, or suspected to have, Alzheimer's disease or a related dementia.

(b) If the person seeking assistance meets the criteria in paragraph (a), the center may provide assistance to the caregiving family, subject to the availability of funds and resources.

Section 5. Effective upon the adoption of rules establishing minimum standards for memory care services licensees pursuant to s. 429.076, Florida Statutes, ss. 429.177 and 429.178, Florida Statutes, are repealed.

Section 6. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to memory care; amending s. 429.02, F.S.; defining terms; amending s. 429.07, F.S.; requiring licenses for assisted living facilities that provide memory care services; making technical changes; creating s. 429.076, F.S.; requiring an assisted living facility that serves memory care residents or holds itself out as providing memory care services to obtain a memory care services license; providing an exception; requiring an assisted living

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facility to maintain certain licensure and meet certain requirements in order to obtain a memory care services license; requiring the Agency for Health Care Administration to adopt rules governing memory care services licenses by a specified date; specifying requirements for such rules; requiring an assisted living facility licensed on or after the effective date of such rules to obtain a memory care services license to carry out certain functions; requiring an assisted living facility licensed before the effective date of such rules to obtain a memory care services license at the time such facility renews its licensure; authorizing a facility that served memory care residents without a memory care services license prior to a specified date to continue to do so if certain requirements are met; requiring a facility without a memory care services license to meet specified requirements if a memory care resident decides to remain at the facility despite the lack of such license; creating s. 430.71, F.S.; providing the purpose of the Florida Alzheimer's Center of Excellence; defining terms; creating the center within the Department of Elderly Affairs; authorizing the center to contract for services; providing duties of the center; requiring the center to submit an annual report to the Governor and the Legislature by a specified date; specifying requirements for the report; specifying eligibility requirements for services; authorizing the center to provide assistance

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to qualified persons, subject to the availability of funds and resources; repealing ss. 429.177 and 429.178, F.S., relating to patients with Alzheimer's disease or other related disorders and certain disclosures and special care for persons with Alzheimer's disease or other related disorders, respectively, upon the adoption of certain rules; providing an effective date.

By Senator Burton

12-01086-26 20261404__

A bill to be entitled

An act relating to memory care; amending s. 429.177, F.S.; defining the term "memory care services"; requiring facilities claiming to provide memory care services to meet specified standards of operation in providing such services; providing applicability; specifying requirements for resident contracts; specifying requirements for facilities with a resident who experiences certain changes of condition; specifying staffing requirements for facilities providing memory care services; repealing s. 429.178, F.S., relating to special care for persons with Alzheimer's disease or other related disorders; creating s. 430.71, F.S.; providing the purpose of the Florida Alzheimer's Center of Excellence; defining terms; creating the center within the Department of Elderly Affairs; authorizing the center to contract for services; providing duties of the center; requiring the center to submit an annual report to the Governor and the Legislature by a specified date; specifying requirements for the report; specifying eligibility requirements for services; authorizing the center to provide assistance to qualified persons, subject to the availability of funds and resources; providing effective dates.

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

Section 1. Effective January 1, 2027, section 429.177,

Florida Statutes, is amended to read:

429.177 Patients with Alzheimer's disease, dementia, or other memory ~~related~~ disorders; certain disclosures; minimum standards.—

(1) As used in this section, the term "memory care services" means specialized or focused care and services designed to address health or behavioral issues resulting from Alzheimer's disease, dementia, or other memory disorders.

(2)(a) A facility that advertises itself as a memory care provider or otherwise claims that the facility provides memory care services, including, but not limited to, services for residents with Alzheimer's disease, dementia, or other memory disorders, must:

1. Develop and implement policies and procedures addressing all of the following:

a. Admittance criteria.

b. Care and services necessary to address the needs of persons admitted for memory care services;

2. Offer activities specifically designed for persons admitted for memory care services; and

3. Maintain a current and accurate log of residents admitted for the purpose of receiving memory care services.

(b) The standards in paragraph (a) apply to any unit designated for the provision of memory care services or to a facility that provides memory care services to any resident admitted and requiring such services.

(3) In addition to the requirements of s. 429.24, resident contracts must specify all memory care services to be provided and any costs related to such services which exceed standard

room and board.

(4) In addition to the requirements of s. 429.26(7), for persons residing in facilities providing memory care services who exhibit a change of condition, the facility shall:

(a) Notify a licensed physician to ensure that appropriate care is provided to the resident. The notification must occur within 30 days after the acknowledgment of such changes in condition by facility staff.

(b) Notify the resident's representative or designee and assist in making appointments for the necessary care and services for treatment of the change in condition.

(c) If the resident does not have a representative or designee, or if the resident's representative or designee cannot be located or is unresponsive, arrange with the appropriate health care provider for the necessary care and services for treatment of the change in condition.

(5)(a) A facility providing memory care services, or a specific unit of a health care facility which is designated for memory care services, must have at least one staff member present to provide care and services at all times. The staff member shall:

1. Stay awake at all times.

2. Meet any training required as defined by statute or rule for assisted living facilities, including the training and continuing education requirements of s. 430.5025.

3. Be certified in first aid and cardiopulmonary resuscitation.

(b) A staff member administering medication or providing assistance with the self-administration of medication does not

count toward the staffing requirement specified in paragraph (a) when he or she is engaged in such tasks.

(6) A facility licensed under this part which claims that it provides special care for persons who have Alzheimer's disease, dementia, or other memory ~~related~~ disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The facility must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease, dementia, or other memory ~~related~~ disorders offered by the facility and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the facility's records as part of the license renewal procedure.

Section 2. Effective January 1, 2027, section 429.178, Florida Statutes, is repealed.

Section 3. Section 430.71, Florida Statutes, is created to read:

430.71 Florida Alzheimer's Center of Excellence.—

(1) PURPOSE AND INTENT.—The purpose of this section is to assist and support persons with Alzheimer's disease or related forms of dementia and their caregivers by connecting them with resources in their communities to address the following goals:

(a) To allow residents of this state living with Alzheimer's disease or related forms of dementia to age in place.

(b) To empower family caregivers to improve their own well-

being.

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

(a) "Center" means the Florida Alzheimer's Center of Excellence.

(b) "Department" means the Department of Elderly Affairs.

(3) POWERS AND DUTIES.—

(a) There is created within the department the Florida Alzheimer's Center of Excellence, which shall assist in improving the quality of care for persons living with Alzheimer's disease or related forms of dementia and improving the quality of life for family caregivers. The center may contract for services necessary to implement this section. The center shall do all of the following:

1. Conduct caregiver assessments to measure caregiver burden.

2. Create personalized plans that guide caregivers to community resources, empowering them with the skills, education, support, and planning necessary for effective caregiving, including addressing any medical, emotional, social, legal, or financial challenges experienced by the person with Alzheimer's disease or a related form of dementia.

3. Educate and assist caregivers with strategies for caregiving for someone with Alzheimer's disease or a related form of dementia and provide guidance on all aspects of home-based care, including home safety, physical and mental health, legal and financial preparedness, communication skills, and hands-on care techniques.

4. Provide online educational resources for caregivers.

5. Track outcomes, including, but not limited to, decreased

hospitalizations, reduced emergency department visits, reduction in falls, and reduction in caregiver burnout.

6. By December 1 of each year, submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which addresses the number of families served, the types of services provided, and the outcomes achieved.

(b) The center shall work with area agencies on aging as defined in s. 430.203; the Alzheimer's Disease Advisory Committee established under s. 430.501; the Alzheimer's Disease Initiative established under ss. 430.501-430.504; the state-funded memory disorder clinics established under s. 430.502; the department's Dementia Care and Cure Initiative task forces; universities; hospitals; and other available community resources to ensure full use of the state's infrastructure.

(4) ELIGIBILITY FOR SERVICES.—

(a) To qualify for assistance from the center, an individual or a caregiver must meet all of the following criteria:

1. At least one person in the household is a caregiver for a person diagnosed with, or suspected to have, Alzheimer's disease or a related form of dementia.

2. The caregiver or the person diagnosed with, or suspected to have, Alzheimer's disease or a related form of dementia is a resident of this state.

3. The person seeking assistance has the goal of providing in-home care for the person diagnosed with, or suspected to have, Alzheimer's disease or a related form of dementia.

(b) If the person seeking assistance meets the criteria in

paragraph (a), the center may provide assistance to the caregiving family, subject to the availability of funds and resources.

Section 4. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2026.

Tab 6

2/2/26
Meeting Date

HP
Committee

The Florida Senate
APPEARANCE RECORD

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

1404
Bill Number or Topic

537686
Amendment Barcode (if applicable)

Name Jason Hand

Phone 850-443-0029

Address 2252 Wadsworth Street
Street

Email jhand@floridasurveying.org

Tallahassee FL 32308
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[X] I am a registered lobbyist, representing: Florida Surveying 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

Feb 2, 2026
Meeting Date

Health Policy
Committee

SB 1404
Bill Number or Topic

Amendment Barcode (if applicable)

Name Brian Jogerst

Phone 850 933 1985

Address PO Box 11094
Street

Tallahassee FL 32302
City State Zip

Email Brian@thegriffingroup.com

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: Elder Law Section / Florida Bar

☐ 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

2/2/26
Meeting Date

Health Policy
Committee

1404
Bill Number or Topic

Amendment Barcode (if applicable)

Name Tyler Jefferson

Phone 850 543 2165

Address 1432 Oldfield Dr
Street

Email tdjefferson@alz.org

Tallahassee FL 32308
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Alzheimer's 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

APPEARANCE RECORD

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

2/2/26 - 3:30 PM
Meeting Date

Health Policy
Committee

1404 - Memory Care
Bill Number or Topic

Amendment Barcode (if applicable)

Name AARP - Karen Murillo

Phone 850-567-0414

Address 215 S. Monroe St., Ste. 603
Street

Email kmurillo@aarp.org

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP 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 Committee on Health Policy

BILL:	CS/SB 914
INTRODUCER:	Health Policy Committee and Senator Calatayud
SUBJECT:	Dry Needling
DATE:	February 3, 2026
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 914 authorizes occupational therapists to perform dry needling and directs the Board of Occupational Therapy Practice to adopt minimum training, supervision, consent, and documentation standards for the performance of dry needling.

The bill also requires the Department of Health (DOH) to produce a report by December 31, 2028, on workforce trends and adverse incidents related to occupational therapists performing dry needling.

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

II. Present Situation:

Occupational Therapy

Occupational therapy is the therapeutic use of occupations (meaningful daily activities) through habilitation, rehabilitation, and the promotion of health and wellness to support participation and function in home, school, work, and community settings.[1] Occupational therapy services are provided to clients who have, or are at risk of developing, an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.[2]

[1] Section 468.203(4), F.S.
[2] *Id*.

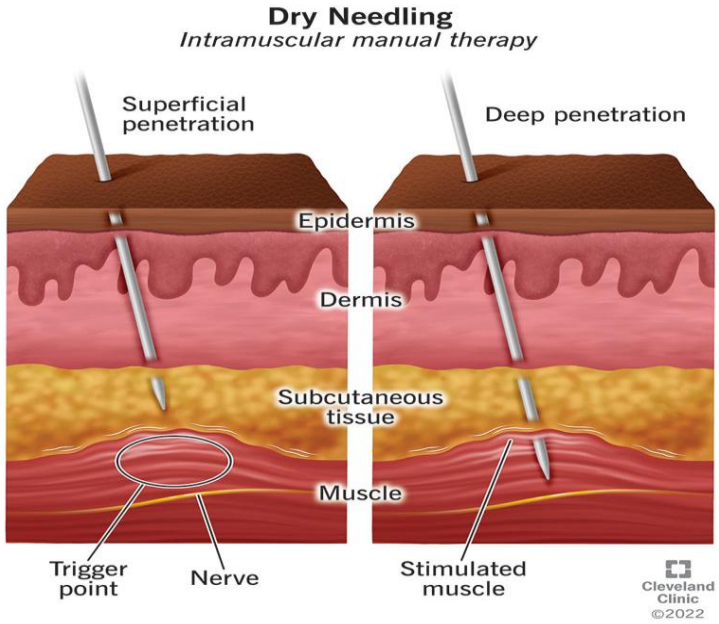
Occupational therapists are regulated under part III of ch. 468, F.S. They are licensed by the DOH and regulated through the Board of Occupational Therapy Practice. The DOH recently reported that Florida regulates approximately 13,712 occupational therapists.[3]

To become initially licensed as an occupational therapist in Florida, an applicant must:[4]

- Graduate from an occupational therapy program accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education;
- Complete a minimum of six months of supervised fieldwork within that program; and
- Pass the examination administered by the National Board for Certification in Occupational Therapy.[5]

Dry Needling[6]

Dry needling is a method for treating muskoskeletal pain and movement issues, typically used as part of a larger pain management plan which may include exercise, stretching, massage, and other techniques. During a dry needling treatment, a provider inserts thin sharp needles through the skin to treat underlying myofascial trigger points. Dry needling can decrease tightness, increase blood flow, and reduce local and referred pain. The needles are "dry" because they don't contain any medication and nothing is injected through the skin. Dry needling may include superficial and deep penetration.



[3] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2024-25*, at 27, available at https://mqawebteam.com/annualreports/2425/2/ (last visited Jan. 28, 2025).
[4] Section 468.209, F.S.
[5] Department of Health. *Senate Bill 914 Legislative Analysis* (Dec. 17, 2025) (on file with the Senate Committee on Health Policy).
[6] Cleveland Clinic, *Dry Needling*, (last reviewed Feb. 20, 2023) *available at* https://my.clevelandclinic.org/health/treatments/16542-dry-needling (last visited Jan. 29, 2026).

According to the DOH, the following professions may perform dry needling in Florida according to their respective practice acts: physicians, osteopathic physicians, physical therapists,[7] licensed acupuncturists, chiropractic physicians,[8] and athletic trainers.[9]

Acupuncture and dry needling use the same type of needles, but they're based on different approaches and goals. Acupuncture is performed by acupuncturists and comes from Eastern medicine, treating not only musculoskeletal pain but also other body systems, while dry needling is rooted in Western medicine, uses assessment of pain and movement patterns, and targets muscle tissue to reduce pain, release trigger points, and improve movement often as part of a larger pain management plan.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 468.203, F.S., to define terms for the Occupational Therapy Practice Act within part III of ch. 468, F.S.:

- "Dry needing" is defined as a skilled intervention, based on Western medicine, that uses filiform needles and other apparatus or equipment to stimulate a myofascial trigger point for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disabilities.
- "Myofascial trigger point" is defined as "an irritable section of soft tissue often associated with palpable nodules in taut bands of muscle fibers."

Section 2 of the bill creates s. 468.222, F.S., within the Occupational Therapy Practice Act to authorize dry needling within the practice and to establish related standards and requirements.

The bill requires the Board of Occupational Therapy Practice to adopt minimum standards of practice for an occupational therapist to perform dry needling. At a minimum, the standards must require:

- At least two years of licensed practice as an occupational therapist;
- Completion of 50 hours of face-to-face continuing education on dry needling from an entity approved by the Board, including instruction in dry needling theory, needle selection and handling (including biohazardous waste handling), indications and contraindications, psychomotor skills, and postintervention care (including adverse response care, adverse incident recordkeeping, and any reporting obligations); and
- Demonstration of requisite psychomotor skills, as determined by the continuing education instructor.

The bill also requires the Board to establish supervision and training standards for clinical experience before independently performing dry needling. Specifically, an occupational therapist must complete at least 25 patient sessions of dry needling performed under supervision, with documentation by the supervising practitioner that the supervised occupational therapist has met the Board's supervision and competency requirements, which must be adopted by rule, and does not require additional supervised sessions. The bill authorizes supervision by an occupational

[7] Section 486.117, F.S.
[8] Section 460.4085, F.S.
[9] *Supra* note 5.

therapist, a physical therapist, or a chiropractic physician who holds an active license to practice in any state of the District of Columbia and has actively performed dry needling for at least one year. Alternatively, the bill allows satisfaction of the 25-session requirement through dry needling patient sessions performed while licensed in another state or while serving in the U.S. Armed Forces.

The bill requires that dry needling be performed only with patient consent and only when it is part of the patient's documented plan of care. The bill prohibits delegation of dry needling to any person other than an occupational therapist who is authorized to engage in dry needling under part III of ch. 468, F.S.

The bill authorizes the Board to impose additional supervision and training requirements before an occupational therapist may perform dry needling on the head, neck, or torso, if the Board deems such requirements necessary for patient safety.

The bill requires the DOH, within existing resources, to submit a report to the President of the Senate and the Speaker of the House of Representatives by December 31, 2028. The report must detail:

- The total number of occupational therapists licensed in Florida;
- The number who perform dry needling;
- Geographic increases or decreases in occupational therapists; and
- The number of adverse medical incidents, as defined by board rule, involving occupational therapists performing dry needling in this state.

Finally, the bill provides that the performance of dry needling in occupational therapy may not be construed to limit the scope of practice of other licensed health care practitioners not governed by ch. 468, F.S.

Section 3 of the bill provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 468.203 of the Florida Statutes.

This bill creates section 468.222 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 February 2, 2026:
The CS requires the Board of Occupational Therapy to approve continuing education courses on dry needling, which would be completed by occupational therapists seeking to practice dry needling. It also broadens the pool of practitioners who may supervise the occupational therapist's 25 patient sessions of dry needling to include certain physical therapists and chiropractic physicians, in addition to occupational therapists as provided in the underlying bill.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Calatayud) recommended the following:

Senate Amendment

Delete lines 41 - 80
and insert:
education from an entity approved by the board on the topic of dry needling. To satisfy this requirement, the instructor of the continuing education must make a determination that the occupational therapist demonstrates the requisite psychomotor skills to safely perform dry needling. The continuing education must include instruction in all of the following areas:

507366

1. Theory of dry needling.

2. Selection and safe handling of needles and other apparatus or equipment used in dry needling, including instruction on the proper handling of biohazardous waste.

3. Indications and contraindications for dry needling.

4. Psychomotor skills needed to safely perform dry needling.

5. Postintervention care, including care for adverse responses, adverse incident recordkeeping, and any reporting obligations.

(c)1. Completion of at least 25 patient sessions of dry needling performed under the supervision of an occupational therapist, a physical therapist, or a chiropractic physician who holds an active license to practice in any state or the District of Columbia and has actively performed dry needling for at least 1 year. The supervising practitioner must document that the occupational therapist under his or her supervision has met the supervision and competency requirements specified by board rule and does not need additional supervised sessions to safely perform dry needling; or

2. Completion of 25 patient sessions of dry needling performed as an occupational therapist, physical therapist, or chiropractic physician licensed in another state or in the United States Armed Forces.

(d) A requirement that dry needling be performed only if the patient consents to the treatment and it is part of the patient’s documented plan of care.

(e) A requirement prohibiting the delegation of dry needling to any person other than an occupational therapist who

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is authorized to perform dry needling under this part.

(2) The board shall establish additional supervision and training requirements that an occupational therapist must meet before performing dry needling on the head, neck, or torso if the board deems such requirements necessary for patient safety.

(3) The Department of Health shall, within existing resources, submit

By Senator Calatayud

38-00925-26 2026914__

A bill to be entitled

An act relating to dry needling; amending s. 468.203, F.S.; defining the terms "dry needling" and "myofascial trigger point"; creating s. 468.222, F.S.; requiring the Board of Occupational Therapy to establish minimum standards of practice for the performance of dry needling by occupational therapists, including specified standards; requiring the board, if it deems it necessary for patient safety, to adopt additional supervision and training requirements for occupational therapists to perform dry needling on specified areas; requiring the Department of Health to submit a report of specified information to the Legislature by a specified date; providing construction; providing an effective date.

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

Section 1. Present subsections (3) through (8) of section 468.203, Florida Statutes, are redesignated as subsections (5) through (10), respectively, and new subsections (3) and (4) are added to that section, to read:

468.203 Definitions.—As used in this act, the term:

(3) "Dry needling" means a skilled intervention, based on Western medicine, that uses filiform needles and other apparatus or equipment to stimulate a myofascial trigger point for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disabilities.

(4) "Myofascial trigger point" means an irritable section

of soft tissue often associated with palpable nodules in taut bands of muscle fibers.

Section 2. Section 468.222, Florida Statutes, is created to read:

468.222 Dry needling.—

(1) The board shall establish minimum standards of practice for the performance of dry needling by occupational therapists, including, at a minimum, all of the following:

(a) Completion of 2 years of licensed practice as an occupational therapist.

(b) Completion of 50 hours of face-to-face continuing education from an entity accredited in accordance with s. 468.209 on the topic of dry needling. To satisfy this requirement, the instructor of the continuing education must make a determination that the occupational therapist demonstrates the requisite psychomotor skills to safely perform dry needling. The continuing education must include instruction in all of the following areas:

1. Theory of dry needling.

2. Selection and safe handling of needles and other apparatus or equipment used in dry needling, including instruction on the proper handling of biohazardous waste.

3. Indications and contraindications for dry needling.

4. Psychomotor skills needed to perform dry needling.

5. Postintervention care, including care for adverse responses, adverse incident recordkeeping, and any reporting obligations.

(c)1. Completion of at least 25 patient sessions of dry needling performed under the supervision of an occupational

therapist who holds an active license to practice occupational therapy in any state or the District of Columbia and has actively performed dry needling for at least 1 year. The supervising occupational therapist must document that the occupational therapist under his or her supervision has met the supervision and competency requirements specified by board rule and does not need additional supervised sessions to safely perform dry needling; or

2. Completion of 25 patient sessions of dry needling performed as an occupational therapist licensed in another state or in the United States Armed Forces.

(d) A requirement that dry needling be performed only if the patient consents to the treatment and it is part of the patient's documented plan of care.

(e) A requirement prohibiting the delegation of dry needling to any person other than an occupational therapist who is authorized to engage in dry needling under this part.

(2) The board shall establish additional supervision and training requirements an occupational therapist must meet before performing dry needling on the head, neck, or torso if the board deems such requirements necessary for patient safety.

(3) The department shall, within existing resources, submit a report to the President of the Senate and the Speaker of the House of Representatives on or before December 31, 2028, detailing the total number of occupational therapists licensed in this state, the number of occupational therapists who perform dry needling in this state, any increases or decreases in the number of occupational therapists in this state by geographic area, and the number of any adverse medical incidents, as

defined by board rule, involving the performance of dry needling by occupational therapists in this state.

(4) The performance of dry needling in the practice of occupational therapy may not be construed to limit the scope of practice of other licensed health care practitioners not governed by this chapter.

Section 3. This act shall take effect July 1, 2026.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 5, 2026

I respectfully request that **Senate Bill #914**, relating to Dry Needling, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Alexis Calatayud

Senator Alexis Calatayud
Florida Senate, District 38

File signed original with committee office

S-020 (03/2004)

Tab 7

The Florida Senate

APPEARANCE RECORD

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

2/2/26
Meeting Date

Health Pol
Committee

914
Bill Number or Topic

507366
Amendment Barcode (if applicable)

Name Corinne Mixon Phone 766 579[illegible]

Address 119 S. Monroe Email corinnemixon@gmail.com
Street

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Acupuncture Medical 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

FEB 2, 2020
Meeting Date

Health Policy
Committee

914
Bill Number or Topic

Amendment Barcode (if applicable)

Name Anita Berry

Phone 301 524 0172

Address 21748 SR 54, STE 101
Street

Email anita@jonnatanawa.com

LUTZ FL 33549
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 Occupational Therapy 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

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1758
INTRODUCER:	Health Policy Committee and Senators Gaetz and Brodeur
SUBJECT:	Public Assistance
DATE:	February 4, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rainer	Brown	HP	**Fav/CS**
2.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1758 makes several changes to Florida's administration of the Florida Medicaid Program and the Supplemental Nutrition Assistance Program (SNAP).

For Medicaid, the bill:

- Creates s. 409.9041, F.S., to enact work or community engagement requirements for program recipients to be eligible for Medicaid.
- Amends s. 409.906, F.S., to authorize the Agency for Health Care Administration (AHCA) to prepare for filing a waiver relating to home and community-based behavioral health services designed to cover an expanded array of such services to adults with serious mental illness who are high utilizers of such services in institutional settings.
- Amends ss. 409.91195 and 409.912, F.S., to permit the AHCA to develop and publish a preferred physician-administered drug list, preferred product list, and high-cost drug list to promote the AHCA's cost-effective purchasing of prescribed drugs and therapeutic supplies.
- Creates s. 409.912(a)5., F.S., to authorize the AHCA to reimburse hospitals for long-acting injectables to patients with severe mental illness, outside of the diagnosis-related group reimbursement system that applies to inpatient care.
- Creates s. 409.912(a)6., F.S., which allows the AHCA to engage a vendor and perform a study as to various issues concerning the federal 340B Discount Drug Purchase program.
- Amends ss. 409.904, 409.905, 409.912, and 409.913, F.S., to clarify that the AHCA may perform retrospective audits of provider claims that received prior authorization.
- Amends s. 409.913, F.S., to authorize the AHCA to send overpayment notice to providers by other common carriers in addition to the U.S. Postal Service.

The bill amends Florida's SNAP statutes to align state law with recently enacted federal requirements and to address Florida's elevated SNAP payment error rate. The bill:

- Creates s. 414.321, F.S., to codify federal SNAP eligibility requirements related to citizenship and immigration status and require all SNAP participants to provide documentation verifying shelter and utility expenses at application and redetermination.
- Creates s. 414.332, F.S., requiring the Department of Children and Families (DCF) to develop and implement a statewide SNAP payment accuracy plan designed to reduce the state's payment error rate to below six percent. The plan must be submitted by July 15, 2026, and the DCF must submit quarterly reports from October 1, 2026, through October 1, 2028, to the Governor and Legislature detailing the SNAP payment error rate, error trends, and corrective actions.
- Amends s. 414.455, F.S., to require the DCF to issue SNAP electronic benefit transfer (EBT) cards that include photographic identification, to the extent allowed under federal law.
- Amends s. 414.455, F.S., to expand SNAP employment and training (E&T) participation requirements to individuals aged 18 through 64 who do not have a child under the age of 14, replacing the current statutory upper age limit of 59 and the exemption for individuals with a child under age 18.

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

II. Present Situation:

Medicaid Program

The Medicaid Program was established in 1965 under federal law. The Medicaid Act is codified as Title XIX of the Social Security Act and ch. 409, parts III and IV, of the Florida Statutes.[1] The purpose of the program is to provide medical assistance to the "categorically needy." It is a voluntary program for the states' participation. Florida has opted to participate in the Medicaid program.

Medicaid is a cooperative health care program jointly funded by the states and federal government. While it is a voluntary program, once a state elects to participate, the state must comply with all federal and statutory requirements. As a cooperative program, it is jointly funded by the state and federal government.[2] The federal government at this time is providing a sixty percent match with the remaining forty percent coming from the state.[3] The federal match is known as the Federal Medical Assistance Percentages (FMAP).[4]

[1] 42 U.S.C. § 1396 et seq.
[2] 42 U.S.C. §§ 1396b
[3] Federal Register, 54696/Vol. 90, No.227/Friday, November 28, 2025/Notices, available at https://www.govinfo.gov/content/pkg/FR-2025-11-28/pdf/2025-21332.pdf; The federal share for Florida Medicaid during the federal fiscal year starting October 1, 2026, will be 55.43 percent.
[4] *Id.* FMAP is used for the Medicaid, TANF , child support collection, Child Care Mandatory and Matching Fuds of the Child Care and Development Fund, Title IV-E Foster Care Maintenance payments, and Kinship Guardianship Assistance programs. There is also an Enhanced Federal Matching Assistance Percentage (eFMAP) which applies to the Children's Health Insurance Program (CHIP).

On the federal side of the program, Medicaid is administered by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). In the State of Florida, the AHCA is designated as the "single state agency" for purposes of interacting with the CMS as to supervision and administration of the state Medicaid plan under federal law.[5] The Department Children and Families (DCF) is designated as the agency which determines if an individual is eligible for Medicaid assistance.[6] For all other aspects of the Medicaid program, the AHCA is responsible.[7]

To qualify a state for federal funding, the CMS must approve the state's Medicaid plan, or "state plan," which sets out numerous parameters for running the program.[8] It is also possible for the state to obtain an 1115, 1915(a), or 1915(b) waiver. A section 1115 waiver gives the CMS the "authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs."[9] The 1915(a) and 1915(b) waivers are utilized for implementing and changing a state's managed care delivery system.

As of December 31, 2025, 3,928,797 persons were enrolled in Florida Medicaid.[10] Overall, the Medicaid Program in Florida, is budgeted to expend approximately $35.1 billion for state fiscal year 2025-2026.[11]

The One Big Beautiful Bill Act

On July 4, 2025, the federal law sometimes known as the One Big, Beautiful Bill Act (H.R.1, 2025, or OBBBA) was signed and became effective. The OBBBA deals with various tax and spending items. The law implements work requirements for Medicaid adults under the age of 65 who are Medicaid-eligible in states that chose to expand their Medicaid eligibility under the Affordable Care Act, with a long list of exemptions. The OBBBA applies its work requirements to such adults who are part of their states' expansion population.[12]

The OBBBA also requires a check of a person's eligibility upon application and at least every six months if the person is required to participate in work activities.[13] The work program is mandatory for states that have implemented Medicaid expansion.[14] Forty-one states (including

[5] Section 409.902(15), F.S.; see also 42 C.F.R. § 431.10
[6] Sections 409.902(15) and (19), F.S.
[7] State of Florida, State Plan, available at: https://ahca.myflorida.com/content/download/5971/file/2021wu_Section_1-Single_State_Agency.pdf (last visited Jan. 30, 2026)
[8] 42 U.S.C. §§ 1396a
[9] Medicaid.gov, *Managed Care Authorities,* available at: https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities (last visited Jan. 30, 2026).
[10] Number of Medicaid Eligibles by Age By Assistance Category as of Dec. 31, 2025.
[11] Office of Program Policy Analysis and Government Accountability, *Agency for Health Care Administration,* available at: https://oppaga.fl.gov/ProgramSummary/ProgramDetail?programNumber=5048 (last visited Jan. 30, 2026).
[12] Hinton, Diana,and Rudowitz, *A Closer Look at the Work Requirement Provisions in the Federal Budget Reconciliation Law,* KFF, July 30, 2025; https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/ (last visited Jan. 30, 2026)
[13] Section 7119 of HR 1, (42 U.S.C. §1396a)
[14] *Id*.

Washington, D.C.) are expansion states.[15] Those states must implement the work requirements by December 31, 2026.[16] The ten states[17] which are not expansion states are not so mandated but may do so under a section 1115 waiver or state plan amendment.[18]

Medicaid Eligibility

The DCF Office of Economic Self Sufficiency (ESS) handles eligibility determinations for Medicaid. It also does so for the temporary cash assistance, temporary assistance to needy families (TANF), and food assistance (SNAP) programs.[19] The resources it uses to process and conduct such eligibility determinations are:

- Case workers.[20]
- Various webpages and resources.[21]
- A comprehensive ESS Florida Program Policy Manual.[22]
- Forty-one Family Resources Centers throughout the state.[23]
- A call center.[24]
- The ACCESS Florida system, to collect, verify client information and determine benefit eligibility.[25]
- My ACCESS Customer Portal, which is for individuals to apply for benefits, view programs notices as to their benefits, to self-report changes in household circumstances, renew benefits, and upload documents.

[15] Status of State Medicaid Expansion Decisions, KFF https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/#:~:text=The%20Affordable%20Care%20Act's%20(ACA)%20Medicaid%20expansion,matching%20rate%20(FMAP)%20for%20their%20expansion%20populations (Jan 14, 2026). (last visited Jan. 30, 2026)
[16] Section 7119 of HR 1, (42 U.S.C. §1396a)
[17] *Supra* n. 15
[18] *Supra* n. 16
[19] Chianne D. v. Harris, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 4 (M.D. Fla. Jan. 6, 2026)
[20] They are expected to handle four hundred to six hundred case a month. *Chianne D. v. Harris*, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 30 (M.D. Fla. Jan. 6, 2026) The monthly volumes have ranged from 145,000 to 268,000. Public Assistance Caseload Report, available at: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.myflfamilies.com%2Fsites%2Fdefault%2Ffiles%2F2026-01%2Fcaseload.xlsx&wdOrigin=BROWSELINK (last visited Feb. 4, 2026).
[21] Department of Children and Families, *Additional Resources and Services,* available at: https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services (last visited Jan. 30, 2026).
[22] Department of Children and Families, *ESS Program Policy Manual,* available available at: https://www.myflfamilies.com/services/public-assistance/additional-resources-and-services/ess-program-manual (last visited Jan. 30, 2026).
[23] Approximately 105,000 people visit a month. People. *Chianne D. v. Harris*, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 42 (M.D. Fla. Jan. 6, 2026)
[24] It operates from 7:00 a.m. to 6:00 p.m. Monday through Friday. Has budget authorization for about 960 positions of which 700 are frontline agents. It receives about 1.6 to 2.5 million calls per month. *Chianne D. v. Harris*, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 33 (M.D. Fla. Jan. 6, 2026)
[25] The system is a legacy mainframe system more than thirty years old. *Chianne D. v. Harris*, No. 3:23-CV-985-MMH-LLL, 2026 WL 32126, at p. 13 (M.D. Fla. Jan. 6, 2026) DCF is in the middle of a modernization project to incrementally replace the ACCESS system. The project has been funded since 2022. It is anticipated to be completed in 2028 and cost an estimated $183 Million. *Id* at p. 16.

The ESS' budget for state fiscal year 2025-26 is a total of $655,976,117 and is authorized to fund 4,573 positions.[26]

Supplemental Nutrition Assistance Program (SNAP)

SNAP is a federal program authorized by the Food and Nutrition Act of 2008 that provides food benefits to low-income families to supplement their grocery budget so they can afford the nutritious food essential to health and wellbeing. Anyone who meets income and other eligibility requirements is entitled by law to receive benefits. SNAP benefits are 100 percent federally funded, although states are responsible for general program administration and ensuring program integrity. State agencies determine the eligibility of individuals and households to receive SNAP benefits and issue monthly allotments of benefits.[27] In Florida, the DCF is the designated state agency responsible for administering the SNAP program.[28] The DCF's process for administering SNAP is memorialized in ch. 65A-1, Florida Administrative Code.

SNAP Alien Eligibility

Under federal law, an individual is eligible to participate in SNAP if the individual resides in the U.S. and is either:

- A citizen or national of the United States;
- A lawfully admitted permanent resident, as defined in 8 U.S.C. §§ 1101(a)(15) and 1101(a)(20), excluding individuals such as visitors, tourists, diplomats, and students who are admitted temporarily and do not intend to abandon a foreign residence;
- An individual granted Cuban or Haitian entrant status as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422); or
- An individual lawfully residing in the United States pursuant to a Compact of Free Association described in 8 U.S.C. § 1612(b)(2)(G).[29]

To ensure compliance with federal SNAP eligibility requirements for citizens and noncitizens, the DCF verifies a SNAP participant's Social Security Number[30] or immigration status through the U.S. Citizenship and Immigration Service, supplemented by documents (e.g., U.S. birth certificate, U.S. passport, Certificate of Naturalization or Citizenship) when appropriate.[31]

According to information provided by the DCF, as of September 17, 2025, there were:

- 162,813 SNAP participants who were lawfully admitted for permanent residence.
- 111,174 SNAP participants who were Cuban or Haitian.

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[26] Transparency Florida, *DCF Economic Self Sufficiency Services,* available at: http://transparencyflorida.gov/OperatingBudget/AgencyDetailLevel.aspx?FY=26&BE=60910708 (last visited Jan. 30, 2026).
[27] 7 U.S.C. §§ 2011-2036b; *SNAP*, Food and Nutrition Service, US Dept. of Agriculture (last visited Jan. 30, 2026), https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program; *State/Local Agency, SNAP*, Food and Nutrition Service, US Dept. of Agriculture (last visited on January 14, 2026), https://www.fns.usda.gov/snap/state.
[28] Supplemental Nutrition Assistance Program (SNAP) | Florida DCF (last visited Jan. 30, 2026), https://myflfamilies.com/services/public-assistance/supplemental-nutrition-assistance-program-snap. (last visited Jan 30, 2026)
[29] 7 U.S.C. § 2015(f).
[30] 65A-1.302, F.A.C.
[31] 65A-1.301, F.A.C.

- 104 SNAP participants who were Compact of Free Association citizens of the Marshall Islands, Micronesia, and Palau.

SNAP Shelter Expense Verification

Federal regulations allow state agencies to set verification standards on certain information;[32] however, it also allows a state to mandate verification using documentary evidence.[33] To calculate shelter and utility expenses for SNAP participants currently, the DCF relies on a verification form[34] that is signed by the landlord of the SNAP participant.[35] For utilities that are marked on the verification form as not being included as part of the SNAP participant's rent payments, the DCF uses statewide standard allowances of $419 for those who incur heating and cooling expenses separate and apart from rent or mortgage, or a basic utility allowance of $339 for those who do not incur heating and cooling but do incur electricity, fuel, water, sewage, or garbage separate and apart from rent or mortgage.[36] State regulation expressly disallows verification via "actual utility expenses" for those allowances.[37]

SNAP Quality Control Incentive

The OBBBA established a SNAP quality control incentive that consists of state-matching-funds requirements for the cost of SNAP benefit allotments. The matching requirements are determined based on a state's SNAP payment error rate and range from a state share of 0 to 15 percent of program allotments. These requirements generally begin in fiscal year 2028.[38]

See section III of this analysis, "Effect of Proposed Changes," for further discussion.

SNAP Photo Identification Requirement

State agencies issue electronic benefits transfer (EBT) cards to SNAP participants under federal SNAP rules.[39] States that are performing sufficiently well in administering SNAP may choose to implement a photo EBT card policy.[40] Before implementation, a state agency must demonstrate to the Food and Nutrition Service that it has successfully administered SNAP in accordance with established program performance standards. At a minimum, a determination of successful administration must consider metrics related to program access; the state's payment error rate; the state's case and procedural error rate; application processing timeliness, including compliance with both the seven-day expedited service standard and the 30-day processing standard; the timeliness of recertification actions; and any other performance measures relevant to the state agency's implementation of photo EBT cards.[41]

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[32] 7 C.F.R. § 273.2(f)(3).
[33] 7 C.F.R. § 273.2(f)(4).
[34] CF-ES 2622, available at https://flrules.org/Gateway/reference.asp?No=Ref-11648. (last visited Feb. 4, 2026).
[35] 65A-1.205(9)(c), F.A.C.
[36] 65A-1.603, F.A.C.
[37] *Id.*
[38] 7 U.S.C. § 2013(a)(2); and *Supplemental Nutrition Assistance Program Provisions of the One Big Beautiful Bill Act of 2025 – Information Memorandum*, Sept. 4, 2025, at pg. 4, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-SNAP-Provisions-Implementation-Memo.pdf.
[39] 7 U.S.C. § 2016; and 7 C.F.R. §274.2(a).
[40] 7 C.F.R. § 274.8(f).
[41] 7 C.F.R. § 274.8(f)(1).

SNAP Work Requirements

All people over the age of 15 and under the age of 60 applying for SNAP are subject to general work requirements.[42] This requires the individual to register for work, accept a suitable job offer, not voluntarily quit or reduce hours below 30, and participate in education and training (E&T) programs. A person who is eligible for SNAP may receive benefits for up to three (consecutive or nonconsecutive) months in a three-year period; however, the person will no longer be eligible after the cumulative three-month period unless they work 20 or more hours per week (averaged monthly), participate in a work program for 20 or more hours per week, are in a qualifying workfare program, or qualify for an exemption.[43] These post three-month-limit work requirements are applicable to all individuals unless they:

- Are under the age of 18 or over the age of 65;[44]
- Have been certified as physically or mentally unfit for employment;[45]
- Have a dependent under the age of 14;[46]
- Are pregnant;[47]
- Are an Indian or Urban Indian;[48]
- Are already meeting work registration requirements through Title IV of the Social Security Act or the Federal-State unemployment compensation system;[49]
- Are responsible for the care of a dependent child under 6 years of age or an incapacitated person;[50]
- Are students enrolled at least half-time in school, training program, or college;[51]
- Are regularly participating in a drug or alcohol treatment and rehab program;[52] or
- Are working at least 30 hours per week or earning the equivalent of the federal minimum wage multiplied by 30 ($217.50/week).[53] [54]

While SNAP work requirements are federally mandated, states do have some flexibility to request waivers under certain conditions and to impose stricter rules if they choose. States can request waivers from the post three-month-limit work requirement if unemployment is above

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[42] 7 U.S.C. § 2015(d)(1).
[43] 7 U.S.C. § 2015(o).
[44] 7 U.S.C. § 2015(o)(3)(A). Federal guidance documents frequently reflect eligibility from ages 18–64; it is as an administrative shorthand that is employed because 64 is the last full year of applicability, with 65 being a partial-year transition.
[45] 7 U.S.C. § 2015(o)(3)(B).
[46] 7 U.S.C. § 2015(o)(3)(C).
[47] 7 U.S.C. § 2015(o)(3)(E).
[48] 7 U.S.C. § 2015(o)(3)(F).
[49] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(A).
[50] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(B).
[51] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(C).
[52] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(D).
[53] 7 U.S.C. §§ 2015(o)(3)(D) and 2015(d)(2)(E).
[54] Congress made changes to SNAP work requirements in 2025, raising the applicable age ceiling to 65 and removing exceptions for homeless individuals, veterans, and those 24 and younger who aged out of foster care. *Supplemental Nutrition Assistance Program Provisions of the One Big Beautiful Bill Act of 2025 – Information Memorandum*, Sept. 4, 2025, at pg. 2, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-SNAP-Provisions-Implementation-Memo.pdf.

10 percent.[55, 56] Additionally, states receive a limited number of discretionary exemptions they can apply to certain covered individuals, such as: an able-bodied adult without dependents who is not working or participating in a qualifying work/training program; SNAP participant denied solely for not meeting the work rule; or a former participant whose prior work exemption expired.[57] States can also implement E&T programs that require more participation than federal minimums.[58]

Medicaid Behavioral Health

Behavioral health is not required to be covered under federal Medicaid law or regulations.[59] Certain aspects of mental services are optional coverage in Florida, e.g. targeted case management and community mental health services, and state psychiatric inpatient hospital care to a recipient over 65 years old.[60] For the Florida Kidcare program, both Medicaid and Medikids are required to provide behavioral health services.[61] The AHCA is also authorized to implement a Medicaid behavioral drug management program.[62]

Various programs and services for behavioral and mental health services are available for coverage and reimbursement under Florida Medicaid. The AHCA has promulgated 14 coverage policies as to behavioral and mental health services.[63] The AHCA has a separate Behavioral Health and Facilities Unit which develops policy and administers such services in behavioral health, hospital, long-term care, and assistive care facilities.[64]

As part of Florida's Statewide Medicaid Managed Care (SMMC) program, managed care plans are required to maintain a network of behavioral health providers, provide behavioral health service as part of early and periodic screening, diagnosis, and treatment (EPSDT), provide care coordination between primary care services and behavioral health service, work with the DCF's

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[55] 7 U.S.C. § 2015(o)(4). *See* also *ABAWD Waivers*, Food and Nutrition Service, US Dept. of Agriculture, https://www.fns.usda.gov/snap/abawd/waivers. (last visited on Jan. 30, 2026)

[56] In 2025, Congress removed the criterion that provides for waiver requests when an area "does not have a sufficient number of jobs to provide employment for the individuals" that reside there. This condition is replaced by an option for areas in Alaska and Hawaii to qualify for a waiver if their unemployment rate reaches or exceeds 150 percent of the national average. All other states may now only request waivers when the unemployment rate meets or exceeds 10 percent in an area. *Supplemental Nutrition Assistance Program Provisions of the One Big Beautiful Bill Act of 2025 – Information Memorandum*, Sept. 4, 2025, at pg. 2, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-SNAP-Provisions-Implementation-Memo.pdf.

[57] 7 U.S.C. § 2015(o)(6).

[58] 7 U.S.C. §§ 2015(d)(1)(A)(ii) and 2015(d)(4).

[59] Section 409.905, F.S.

[60] Section 409.906(5), (8), and (22), F.S.

[61] Section 409.815(2)(g), F.S.

[62] Section 409.912(5)8.a., F.S.

[63] Behavioral Analysis Services, Behavioral Health Assessment Services, Behavioral Health Community Support Services, Behavioral Health Intervention Services, Behavioral Health Medication Management Services, Behavioral Health Overlay Services, Behavioral Health Therapy Services, Florida Assertive Community Treatment Services, Inpatient Hospital Services, Mental Health Targeted Case Management, Specialized Therapeutic Services, State Mental Health, Statewide Inpatient Psychiatric Program, Therapeutic Group Care Services, available at: https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies (last visited Jan. 30, 2026).

[64] Agency for Health Care Administration, *Behavioral Health and Health Facilities,* available at; https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/medical-and-behavioral-health-coverage-policy/behavioral-health-and-health-facilities (last visited Jan. 30, 2026).

applicable managing entity in the service area as to such coordination, and provide, as a minimum benefit, mental health services. The AHCA's contract with managed care plans incorporates the various coverage handbooks for the health plans to follow for providing behavioral and mental health benefits.[65] The AHCA has allowed some substitution or different facilities in the provision of behavioral and mental health benefits under the federal "in lieu of service" (ILOS) program.[66] For the recent SMMC procurement, all of the plans were able to provide a Serious Mental Illness (SMI) product along with their regular Medicaid benefits. All of the plans are awarded (except Florida Community Care) the SMI product. SMI status for an individual is determined by a case finding algorithm of inpatient, outpatient and professional claims, with diagnosis codes for those mental health conditions of long duration and significant impact on daily functioning.[67]

Historically, the federal government has been reluctant to expand Medicaid benefits to include coverage for behavioral and mental health. From its inception in 1965, there was an exclusion to providing reimbursement to facilities classified as an "institution for mental disease" (IMD).[68] An IMD is currently defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[69] Over the years, however, the federal government has increased the ability, in limited cases, to use Medicaid funds for care in IMDs but has not removed the prohibition.[70] The federal government has also recognized the link between primary care and behavioral health.

The CMS announced in 2025 that it has three priorities over the next few years in the expansion of the Medicaid program as to mental and behavioral health benefits:

- Effective benefit design for mental health services for children, youth, and their families.
- Effective benefit design for substance use disorder services.
- Mental Health Parity and Addiction Equity Act (MHPAEA) application to Medicaid programs.[71, 72]

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[65] Managed Medical Assistance Program, Attachment II, Section V.A.1.a, p. 9-10; available at: https://ahca.myflorida.com/content/download/27249/file/Exhibit%20II-A%20Managed%20Medical%20Assistance%20%28MMA%29%20Program%20Oct%202025.pdf (last visited Jan. 30, 2026)

[66] Agency for Health Care Administration, *Statewide Medicaid Managed Care In Lieu of Services,* available at: https://ahca.myflorida.com/content/download/9115/file/ILOS_Program_Highlight_Document_Final_101618.pdf?version=1 (last visited Jan. 30, 2026).

[67] Florida Behavioral Health Association, *New SMMC Contract – Summary of Changes,* p. 2-4; available at: https://floridabha.org/wp-content/uploads/2025/03/Summary-SMMC-Contract-FINAL-Feb-2025-1.pdf (last visited Jan. 30, 2026).

[68] Congressional Research Service, *Medicaid's Institution for Mental Diseases (IMD) Exclusion,* (February 25, 2025); available at: https://www.congress.gov/crs_external_products/IF/PDF/IF10222/IF10222.15.pdf

[69] *Id.*

[70] *Id.*

[71] Behavioral Health Services, available at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services (last visited Jan. 30, 2026).

[72] Mental Health Parity and Addiction Equity Act (MHPAEA), 42 U.S.C.A. § 300gg-26 Requires mental health and substance use disorder services are covered similar to medical benefits. Medicaid plans cannot impose limits on behavioral and mental health services more stringent than those for medical services.

Pharmacy, Drug Purchasing

The acquisition of prescribed drugs is a standard benefit of the Medicaid program and part of the reimbursement to providers.[73] Drugs are sometimes acquired stand-alone and other times are bundled into a prospective payment rate, e.g. diagnosis-related group (DRG), or are part of the Medicaid capitation payment to health plans in SMMC.[74]

The reimbursement of drugs is subject to various statutory requirements.
Section 409.908(14), F.S., limits the reimbursement to the lesser of:

- The actual acquisition cost as contained in the CMS National Average Drug Acquisition Cost pricing files,
- The wholesale acquisition cost,
- The state maximum allowable cost, or
- The usual and customary charge billed,
- Plus a dispensing fee.

In addition, generic drugs must be used generally, with exceptions.[75]

Drugs are currently acquired pursuant to a Preferred Drug List (PDL). The PDL is developed, maintained and reviewed by the AHCA's Medicaid Pharmaceutical and Therapeutics Committee.[76] The committee is composed of 11 members appointed by the Governor – four members are allopathic physicians licensed under ch. 458, F.S., one member is an osteopathic physician licensed under ch. 459, F.S., five members are pharmacists, and one member is a consumer. The duties of the committee are to recommend the contents of the PDL to the AHCA and review the contents at least every twelve months.[77] The committee's standards and considerations for determining whether to include or delete a drug are:

- Is the drug medically appropriate drug therapy for Medicaid patients?[78]
- Does the drug achieve the cost savings contained in the General Appropriations Act?[79]
- Did the manufacturer agree to supplemental rebates as provided by law?[80]
- Does the drug have the requisite United States Food and Drug Administration (FDA) approval for the particular use?[81]
- Clinical efficacy.[82]
- Safety.[83]

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[73] Section 409.815(n), F.S. (Kidcare); s. 409.905(3), F.S. (Mandatory Coverage, Family Planning Services); s. 409.906(20), F.S. (Optional Coverage, Prescribed Drug Services); and s. 409.906(29), F.S. (Optional Coverage, Bio Marker Testing Services).
[74] In plan year 2024 for MMA plans, $3,229,392,040 was spent by the health plans. Retrieved from AHCA Dashboard, Compare Medicaid Financial Data; available at: https://ahca.myflorida.com/medicaid/agency-dashboards (last visited Jan. 30, 2026).
[75] Section 409.908(14)(a), F.S.
[76] Section 409.91195, F.S.
[77] Section 409.91195(4), F.S.
[78] *Id*.
[79] *Id*.
[80] Section 409.91195(7), F.S.
[81] *Id*.
[82] Section 409.91195(8), F.S.
[83] *Id*.

- Cost effectiveness.[84]

The committee may make recommendations as to prior authorization requirements for any recommended drug.[85] The committee is required to allow public testimony before making recommendations to add or delete a drug.[86]

The AHCA must adopt the PDL; however, it does not have to follow the requirements of rulemaking pursuant to ch. 120, F.S. Instead, the AHCA may post the PDL and updates on an internet website.[87] In addition, the list must also comply with the requirement of the Medicaid prescribed-drug spending control program under s. 409.912(5)(a), F.S. The current list is effective as of January 1, 2026, and has been posted.[88]

Federal law gives states the option to provide coverage for prescribed drugs.[89] Florida has elected to do so,[90]as has every other state.[91] To be eligible for the FMAP, the drug must be deemed a covered outpatient drug (COD) by the CMS. As an additional requirement, the manufacturer of the drug and the CMS must have entered into a National Drug Rebate Agreement (NDRA).[92] The state FMAP is paid based on this rebate amount and any supplemental rebates achieved by the state.[93, 94]

States may also place limitations of the coverage of drugs, such as preferred drug lists. Federal law provides that a state may exclude or otherwise restrict coverage as to a COD, if it is on a formulary or part of a prior authorization plan.[95]

Long-Acting Injectables (LAI)

The AHCA, in coordination with the DCF, is authorized to implement a Medicaid behavioral drug management system as part of effective cost management.[96] The AHCA is authorized to implement prescribing practices and patient adherence to medication plans. The authority extends to all behavioral health drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions. Further, the AHCA is authorized to monitor and implement programs to ensure patients engage in medication compliance.

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[84] *Id*.
[85] Section 409.91195(9), F.S.
[86] Section 409.91195(7), F.S.
[87] Section 409.912(5)(a)1., F.S.
[88] Agency for Health Care Administration, *Florida Medicaid Preferred Drug List, Effective January 1, 2026,* available at: https://ahca.myflorida.com/content/download/22289/file/September%202025%20P%26T%20PDL%201.1.2026.pdf (last visited Jan. 30, 2026).
[89] 42 U.S.C. § 1396r-8
[90] Section 409.906(20), F.S.
[91] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Report to Congress, Medicaid Services Investment and Accountability Act of 2019 Preventing the Misclassification of Drugs Under the Medicaid Drug Rebate Program, Federal Fiscal Year 2024* (August 2025), p. 2; Available at: https://www.medicaid.gov/prescription-drugs/downloads/mdrp-misclassification-rtc.pdf (last visited Jan. 30, 2026).
[92] 42 U.S.C. § 1396r-8(a)(1).
[93] 42 U.S.C. § 1396r-8(b)(1)(B).
[94] Section 409.912(5)(a)1.6. & 7., F.S.
[95] 42 U.S.C. § 1396r-8(d).
[96] Section 409.912(5)8.a., F.S.

In 2012, the Florida Legislature required the AHCA to implement a Diagnosis-Related Groups (DRGs) system for paying hospital inpatient claims.[97] DRGs are based on the principal diagnosis, secondary diagnoses, surgical procedures, age, sex, and discharge status of the patients treated.[98] DRGs are classified and implemented using the latest version of the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-CM/PCS) code set.[99]

The AHCA reports that the DRG system is experiencing an unintended consequence for high-risk patients with schizophrenia or bipolar disorder.[100] In 2024, there were approximately 5,700 Medicaid recipients with such diagnoses and approximately 9,100 hospital inpatient admissions for such recipients. Of those hospital admissions, 3,400 were readmissions. The AHCA has determined that medication noncompliance is related to 50 percent of such readmissions.

The average DRG reimbursement of an inpatient admission for schizophrenia or bipolar disorder is $4,200. The DRG includes not only the inpatient stay and cost of any therapies, but also any drugs administered. Such patients may be administered high-priced LAI to treat these disorders. The administration of such LAI should decrease noncompliance rates, reduce readmissions, and improve patient outcomes. Given the bundled DRG rate, some providers are reluctant to administer such drugs, given the fact that the DRG payment is consumed by the costs of the inpatient stay and other therapies administered. By allowing for separate reimbursement (outside of the DRG) for LAI, it is expected that readmissions will decline and the drugs will become rebate eligible.[101]

340B Program

Another drug reimbursement program adopted by federal law is pursuant to 340B of the Public Health Service Act.[102] It is a drug pricing program that requires drug manufacturers to provide to certain "covered entities" outpatient drugs at deeply discounted prices. A manufacturer who wants to participate in the NDRA and state Medicaid drug sales must agree to participate in the program.[103]

Covered entities are:
- Federally qualified health centers;
- Ryan White HIV/AIDS Program Grantees;
- Hospitals; and
- Specialized clinics.

[97] Section 409.905(5)(f), F.S., currently s. 409.905(5)(c), F.S. (2025)
[98] Centers for Medicare & Medicaid Services, Design and development of the Diagnosis Related Group, p. 14; https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last visited Jan. 30, 2026)
[99] *Id*.
[100] Agency for Health Care Administration, *Senate Bill 1758 Fiscal Analysis* (Jan.2026) (On file with staff of the Senate Committee on Health Policy).
[101] *Id*.
[102] 42 U.S.C. § 256b.
[103] 42 U.S.C. § 256b(a)(1).

Covered entities must recertify eligibility every year.[104]

Covered entities are permitted to buy drugs at a ceiling price.[105] The ceiling price is the average manufacturer price minus the Medicaid unit rebate amount.[106] The price can be further reduced by discounts negotiated by the covered entity or prime vendor, directly with the manufacturer (340B price).[107] The covered entity is able to buy all of its drugs at such 340B price, including those for patients who have private or commercial insurance, and are in Medicare or Medicaid managed care plans, or charity care.[108] The covered entity can then collect the difference in negotiated price with the insurer or managed care organization.[109] Federal law also prohibits states from billing rebates on drugs that have already been discounted through the 340B program ("duplicate discounts").[110]

The 340B program has experienced significant growth. In 2021, it is estimated that 50,000 covered entities participate in the program.[111] Significant issues have developed within the program as to covered entities' expansive use, through contract pharmacies, and appropriate reporting. Concerns have been raised by Medicaid programs as to duplicate discounts. A significant amount of litigation has occurred on all these topics.[112]

Medicaid Retrospective Reviews

An important part of the Medicaid program is its ability to conduct audits and reviews of paid claims. The bulk of the AHCA's authority and statutory standards for conducting such audits or reviews are contained in s. 409.913, F.S. Federal Medicaid law also contains numerous instances by which the AHCA or managed care plans must or have the authority to require prior authorization for a particular service.

In a pair of First District Court of Appeal cases, the interplay between prior authorization and retroactive audits was at issue as to certain hospital inpatient services. In the cases of *Lee Mem'l Health Sys. Gulf Coast Med. Ctr. v. Agency for Health Care Admin*., 272 So. 3d 431 (Fla. 1st DCA. 2019) and *N. Broward Hosp. Dist. v. Agency For Health Care Admin*., 398 So. 3d 1038 (Fla. 1st DCA, 2024), *reh'g denied* (Jan. 3, 2025), the factual situation of both cases dealt with a retrospective audit of emergency room claims paid for illegal aliens.

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[104] *Id.*
[105] 42 C.F.R. §10.10
[106] *Id.*
[107] Congressional Budget Office, Growth in the 340B Drug Pricing Program (September 2025), p. 25; available at: https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf (last visited Jan. 30, 2026).
[108] *Id* at p.5.
[109] *Id.*
[110] *Id.* at p.7 fn. 2.
[111] *Id* at p. 1. *See* also fn1.
[112] Congressional Research Service, The 340B Drug Discount Program: Litigation Topics and Trends (September 10, 2025); available at: https://www.congress.gov/crs-product/R48696?q=%7B%22search%22%3A%22r48696%22%7D&s=2&r=1 (last visited Jan. 30, 2026).

Both cases dealt with the language in s. 409.905(5)(a)4., F.S., which states:

> Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program.

This language, which became law in 2002, was a central focus of both courts' decisions.

The Court in the *North Broward* decision did recognize that in 2020, the legislature adopted ch. 2020-156, §§ 38–39, Laws of Fla., so that s. 409.905(5)(a)4., F.S., reads as follows:

> Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program. *However, this subparagraph may not be construed to prevent the agency from conducting retrospective reviews under s. 409.913, including, but not limited to, reviews in which an overpayment is suspected due to a mistake or submission of an improper claim or for other reasons that do not rise to the level of fraud or abuse.* (italics added by Court).

The *North Broward* Court as its legal logic, states: (1) the 2020 amendment declares that it "confirms and clarifies" existing law,[113] and (2) the legislature did not amend s. 409.913(1)(e), F.S., – the definition of "overpayment" to expand AHCA's review of prior authorized claims, nor (3) to include prior authorized claims in s. 409.913(2), F.S., which provides general authorization to "determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program ....". Therefore, the ruling in *Gulf Coast* remains the same.

III. Effect of Proposed Changes:

Section 1 amends s. 490.904(4), F.S., to clarify that the AHCA may conduct retrospective reviews or audit of such claims for necessity or to validate to existence or duration of the emergency medical condition. The existence of a prior authorization of such claim would not prevent such audit or review.

Section 2 creates s. 409.9041, F.S., to establish work or community engagement requirements for able-bodied adults who are receiving or applying for Medicaid benefits.

The AHCA, in consultation with the DCF and the Department of Commerce, would first have to develop and submit a business plan to the Governor and the Legislature as to its implementation of the work requirements. The plan must set forth the methodology that will be to determine the application and exemptions described below. The plan must also set forth the impact it will have on enrollment and Medicaid program expenditures. The procedure developed should provide for eligibility redetermination every six months for affected recipients. An outreach effort to notify recipients of the work requirements must be another component. The plan must be submitted by December 1, 2026, and must be approved by the Legislature before being implemented. The bill

[113] As opposed to stating it repeals *Gulf Coast*. *North Broward* at 1044. The words "confirms and clarifies" are specifically used in Section 39 of ch, 2020-156, §§ 38–39, Laws of Fla., as the Legislative intent.

also directs the AHCA to seek federal waiver approval to implement the bill's mandatory work and community engagement requirements.

Under the bill, all Medicaid able-bodied, adult recipients between the ages of 19 and 64 are to meet the bill's work or community engagement requirements. However, the following individuals are exempt from such work or community engagement requirements:

- Indians as defined by federal law.
- A parent, guardian, caretaker relative or family caregiver of:
  - A child younger than 14 years of age,
  - A disabled individual,
  - To qualify as a caretaker a person must have a significant relationship with the above and must provide a broad range of services.
- Former foster youth under 26 years of age.
- Medically frail persons who:
  - Are in the Medicaid Institutionalized Care Program,
  - Categorized as aged, blind or disabled under the Medicaid program,
  - A developmental disability, as defined in ch. 393, F.S.
- An individual who already meets the work requirements under SNAP.
- An individual in a residential substance use treatment program.
- An inmate in a public institution.
- A woman eligible for Medicaid pregnancy-related or postpartum care.

Affected individuals may satisfy the work or community engagement requirement by participating for 80 hours a month in one or more of the following activities:

- Paid employment,
- On-the-job training,
- Vocational education training,
- Job skills training directly related to employment,
- Education directly related to employment,
- Satisfactory attendance at a secondary school or course of study leading to a high school equivalency diploma,
- Enrollment at least half time in a post-secondary education program to obtain a credential on the Masters Credential list,
- Any other work activity designated by the Department of Commerce, provided by a local workforce development board.

Parents of children between 14 to 18 years old only have to engage in work or community engagement during school hours under the bill.

Individuals found in noncompliance must receive notice. The notice must provide the individual a 30-day grace period to obtain compliance, after which their benefit will be terminated or they can pursue a fair hearing. The notice must also describe the procedure to reapply for Medicaid.

Section 3 amends s. 409.905(5)(a)4., F.S., by deleting the first sentence in that subparagraph, which is one of the bases for the *Gulf Coast* and *North Broward* cases. The bill then amends the second sentence of the subsection to acknowledge it applies to the entire paragraph and permits

reviews of prior-authorized claims. The bill also adds a paragraph (f) to reiterate that the cost-effective purchasing principles of s. 409.912, F.S., apply to the subsection.

Section 4 adds a new subsection (14) to s.409.906, F.S., to add an optional Medicaid service for home and community-based services for behavioral health. The program is to be structured as a federal waiver and is to incorporate the following features:

- Applicable to adults eighteen and older, who:
  - Have a diagnosis of serious mental illness, and
  - Are high utilizers of behavioral health services in an institutional setting.
- Designed to reduce the need for institutional levels of care.

The bill directs the AHCA to work with the DCF on program design and cost estimates. The Legislature must approve the program and appropriate funds before it may be implemented.

Section 5 amends s. 409.91195, F.S. The bill authorizes the Medicaid Pharmaceutical and Therapeutics Committee to develop the following additional lists, in addition to the current Preferred Drug List:

- Medicaid preferred physician-administered drug list.
- Medicaid preferred product list.
- High-cost drug list.

Under the bill, the committee, in addition to drugs purchased by Medicaid through the existing PDL and the bill's new drug lists, must also review and provide recommendations for therapeutic products and devices at least every six months. The lists must be published on the AHCA's website. Before an item is placed on or removed from the new lists, the committee must provide the opportunity for public testimony and the presentation of evidence. The committee must use the same standards of clinical efficacy, safety, and cost effectiveness as it currently uses to develop the PDL.

Section 6 amends s. 409.912(5)(a), F.S., regarding the drug-control spending program to conform to the new lists created under Section 5 of the bill.

The bill creates subparagraph 5. of s. 409.912(5)(a), F.S., to direct the AHCA to compensate health care providers for long-acting injectables to severely mentally ill persons separately from hospital DRG payments.

The bill creates subparagraph 6. of s. 409.912(5)(a), F.S., to direct the AHCA to contract with a vendor to examine issues with the federal 340B program. Issues to be examined are drug purchasing reimbursement, billing, coding, dispensing and reimbursement and rebate interplay with the Medicaid program. The AHCA is directed by the bill to send out data requests to various stakeholders and is given enforcement powers to obtain data. The report is to be submitted by June 30, 2027.

The bill creates subparagraph 14. of s. 409.912(5)(a), F.S., to specify that the AHCA may conduct retrospective reviews and audits of claims even if they were prior authorized.

Section 7 amends s.409.913, F.S., to amend the definition of overpayment to include amounts that were prior authorized and specify that retrospective reviews and audits of claims are authorized even if there is a prior authorization and to make an overpayment determination. Subsection (6) is amended to allow notices to be sent to providers through common carriers other than the U.S. Postal Service.

Section 8 creates s. 414.321, F.S., relating to SNAP eligibility. The bill limits SNAP eligibility to U.S. citizens and nationals, lawful permanent residents, Cuban and Haitian entrants, and individuals covered under the Compact of Free Association (i.e., individuals from the Federated States of Micronesia, the Republic of the Marshall Islands, and Palau). These changes codify federal SNAP alien eligibility requirements into state law, aligning the state requirements with recent changes contained in the OBBBA.[114]

This section also requires SNAP participants to provide documentation evidencing shelter or utility payments during application and redetermination. The DCF is prohibited from relying solely on self-attestation under the bill regarding such payments. This would be a material change from the DCF's current process as it will require the SNAP participant to submit actual bills in order to claim shelter or utility deductions.

Section 9 creates s. 414.332, F.S., relating to a SNAP payment accuracy plan. The bill requires the DCF to develop a comprehensive statewide plan to lower its SNAP payment error rate. The plan must include the following:

- Enhanced employee training and quality assurance, through annual standardized training and frequent reviews of statistically significant samples of cases that incorporate real-time corrective feedback for staff.
- Improvement of data sourcing by maximizing the use of quality automated sources that compare income and asset data with government and private sector data sources.

The bill requires that the payment error rate be reduced to below six percent.

The plan is to be submitted by July 15, 2026. Starting on October 1, 2026, through October 1, 2028, quarterly reports are to be submitted to the Governor and Legislature detailing SNAP error rate, breakdown of payment errors, and corrective action plans.

Florida's SNAP payment error rate was 15.13 percent for federal fiscal year 2024.[115] Pursuant to the OBBBA, if the DCF were to maintain this error rate, the state would be required to pay 15 percent of the cost of all SNAP benefits issued in the state during the fiscal year to which the error rate applies. This is a major fiscal shift, because SNAP benefits have historically been funded 100 percent by the federal government. Payment of state cost share begins in federal fiscal year 2028 unless the state qualifies for delayed implementation, which depends on whether the payment error rate multiplied by 1.5 is equal to or above 20 percent. Based on the delayed implementation criteria, if the DCF can reduce its error rate for federal fiscal year 2025

[114] *Supplemental Nutrition Assistance Program Implementation of the One Big Beautiful Bill Act of 2025 – Alien SNAP Eligibility Information Memorandum*, October 31, 2025, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-Implementation-Memo-Alien-SNAP-Eligibility-Oct31.pdf#page=5. (last visited Jan. 30, 2026).
[115] Fiscal Year 2024 SNAP Quality Control Payment Error Rates, at https://fns-prod.azureedge.us/sites/default/files/resource-files/snap-fy24QC-PER.pdf.

below 13.34 percent, federal fiscal year 2028 is the earliest the state would start to pay the state cost share. If the DCF maintains an error rate at 13.34 percent or higher into federal fiscal year 2026, then federal fiscal year 2030 is the latest the state would start to pay the state cost share.

Section 10 amends s. 414.39, F.S., to require the DCF to issue EBT cards with photographic identification on the front, to the extent authorized under federal law. To implement this section, the DCF will have to demonstrate to the federal Food and Nutrition Service that it has successfully administered SNAP in accordance with established program performance standards.

Section 11 amends s. 414.455, F.S., to require SNAP participants aged 18 through 64, who do not have a child under the age of 14, to participate in employment and training (E&T) programs. Currently in statute, the upper age limit for required participation in E&T programs is set at 59 years of age and it exempts individuals who had a child under the age of 18 in the home. These proposed changes will align state law with the recent changes contained in the OBBBA.[116]

This section also directs the DCF to comply with all exemptions from work requirements in accordance with applicable federal law.

Section 12 makes a conforming change to a statutory reference to align with other provisions in the bill.

Section 13 provides an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None identified.

B. Public Records/Open Meetings Issues:

None identified.

C. Trust Funds Restrictions:

None identified.

D. State Tax or Fee Increases:

None identified.

E. Other Constitutional Issues:

None identified.

[116] U.S. Department of Agriculture, *Supplemental Nutrition Assistance Program Provisions of the One Big Beautiful Bill Act of 2025 – Information Memorandum*, Sept. 4, 2025, at pg. 2, https://fns-prod.azureedge.us/sites/default/files/resource-files/OBBB-SNAP-Provisions-Implementation-Memo.pdf.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None identified.

B. Private Sector Impact:

To the extent persons exit Medicaid under the bill's Medicaid work and community engagement requirements (if the requirements are implemented), such persons could experience a positive fiscal impact, by virtue of obtaining gainful employment, for example, or a negative fiscal impact due to losing Medicaid eligibility after failing to meet the requirements. The bill's work requirements might or might not be implemented because it is unknown whether federal waiver authority will be granted or whether Legislative approval will be granted for the business plan required under the bill.

Hospitals are likely to experience a positive fiscal impact from the bill's provisions relating to reimbursement for long-acting injectables administered on an inpatient basis.

C. Government Sector Impact:

The AHCA has provided the following estimated impacts.[117]

Retrospective Reviews or Audits
According to the AHCA, Medicaid is facing a negative fiscal impact of approximately $12 million based on its inability to audit prior-authorized claims under prevailing case law. The bill contains several different provisions designed to eliminate or mitigate that impact.

Home and Community-based Behavioral Health Services
The AHCA estimates a negative fiscal impact to Medicaid of approximately $25.6 million, with $10.9 million in General Revenue, as a result of the bill's provisions relating to services for home and community-based behavioral health, if those provisions are implemented. These estimates reflect the potential costs to Medicaid and do not include potential cost savings for the DCF under the bill. The DCF has not provided such an estimate. This portion of the bill will not be implemented unless the Legislature appropriates funds in the General Appropriations Act resulting from legislative budget requests submitted by the AHCA and the DCF that estimate both the costs and the savings.

Medicaid Work and Community Engagement Requirements
The AHCA estimates that 111,789 Medicaid recipients may be affected by the bill's work and community engagement requirements. For those individuals, the state expenditures for Medicaid services are estimated at $321 million. Under the assumption that 25 percent of these individuals would be depart from the Medicaid rolls under the bill,

[117] Agency for Health Care Administration, *SB 1758 Fiscal Analysis* (Jan.2026) (on file with Senate Committee on Health Policy).

starting in state fiscal year 2027-2028, savings of approximately $80.2 million could result. No estimates have been provided by the DCF as to extra processing expenses that may be incurred by the department's Office of Economic Self Sufficiency. The bill's work requirements might or might not be implemented because it is unknown whether federal waiver authority will be granted or whether Legislative approval will be granted for the business plan required under the bill.

Long-Acting Injectables (LAI)
The AHCA estimates an overall upfront cost to the Medicaid program for the LAI portion of the bill of $14.8 million per year, with $6.3 million from General Revenue, due to the bill's reimbursement methodology changes and anticipated increase in utilization of LAI. However, over time, the collection of increased LAI rebate revenue under the bill (estimated at $7.4 million starting in the second year) and the elimination of costly services that are typically required when the targeted population is not medicated for severe mental illness, are expected to offset the higher costs initially experienced and result in better care for individuals who need the LAI.

New Medicaid Drug and Product Lists
The AHCA anticipates contracting with a vendor to create and maintain the preferred physician-administered drug list, the preferred product list, and the high-cost drug list. The creation and maintenance of the new lists is anticipated to cost $1.7 million annually. Beginning in the second year, however, the AHCA estimates it will collect an additional $10 million in rebate revenue by virtue of the new drug/product lists.

Fiscal Impact Study to Evaluate the 340B Drug Pricing Program
The AHCA anticipates needing a nonrecurring appropriation of $750,000 in contracted services to contract with a vendor for this study.

SNAP Provisions
Estimates of the bill's operational and fiscal impacts on the administration of the SNAP program by the DCF have not been received by Senate committee staff, as of this writing.

VI. Technical Deficiencies:

None identified.

VII. Related Issues:

None identified.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.904, 409.905, 409.906, 409.91195, 409.912, 409.913, 414.39, 414.455, and 409.91196.

This bill creates the following sections of the Florida Statutes: 409.9041, 414.321, 414.332.

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 February 2, 2026:

The CS makes three changes to the underlying bill regarding the Medicaid Preferred Drug List and the other similar lists created by the bill. The CS:

- Requires the AHCA's Pharmaceutical and Therapeutics Committee to review the contents of the Preferred Drug List and the bill's newly-created lists every six months;
- Requires the Pharmaceutical and Therapeutics Committee to take public testimony before making recommendations to the AHCA about changing the contents of the bill's new High-cost Drug List; and
- Adds requirements for the High-cost Drug List to match requirements for prior authorization that are already in place for the existing Preferred Drug List, in terms of requiring an expeditious response to a request for prior authorization for one of the drugs on the list. Under the CS, a response is required within 24 hours, and a three-day supply of the drug is required to be issued in emergency situations or when the 24-hour deadline for a prior-authorization response is not met.

B. Amendments:

None.

654120

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
02/03/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Gaetz) recommended the following:

Senate Amendment

Delete lines 435 - 436

and insert:

drug list, the preferred product list, and the high-cost drug list every 12 months~~,~~ and may

498120

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Gaetz) recommended the following:

Senate Substitute for Amendment (654120)

Delete lines 435 - 436

and insert:

drug list, the preferred product list, and the high-cost drug list every 6 ~~12~~ months~~,~~ and may

838908

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Gaetz) recommended the following:

Senate Amendment

Delete lines 457 - 461

and insert:

administered drug list, preferred product list, or high-cost drug list. Such public testimony must ~~shall~~ occur before ~~prior to~~ any recommendations made by the committee for inclusion or exclusion from the preferred drug list, preferred physician-administered drug list, preferred product list, or high-cost drug list. Upon timely notice, the agency shall

822634

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/03/2026	.	
	.	
	.	
	.	

The Committee on Health Policy (Gaetz) recommended the following:

Senate Amendment (with title amendment)

Delete line 602
and insert:
chapter 120. The agency must establish procedures to ensure that:

a. There is a response to a request for prior authorization for a high-cost drug by telephone or other telecommunication device within 24 hours after receipt of the request for prior authorization; and

822634

b. A 72-hour supply of the high-cost drug prescribed is provided in an emergency or when the agency does not provide a response to a prior authorization request within 24 hours as required by sub-subparagraph a.

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

And the title is amended as follows:

Delete line 88

and insert:

when posting updates to such lists; requiring the agency to establish certain procedures relating to prior authorization requests for drugs on the high-cost drug list; establishing an

By Senator Gaetz

1-00651C-26 20261758__

A bill to be entitled

An act relating to public assistance; amending s. 409.904, F.S.; authorizing the Agency for Health Care Administration to conduct retrospective reviews and audits of certain claims under the state Medicaid program for a specified purpose; creating s. 409.9041, F.S.; providing legislative findings; requiring the agency to seek federal approval to implement mandatory work and community engagement requirements for able-bodied adults as a condition of obtaining and maintaining Medicaid coverage; prohibiting the agency from implementing such requirements until certain conditions are met; requiring the agency, in consultation with the Department of Children and Families, to develop a business plan to implement specified provisions; specifying requirements for the plan; requiring the agency to submit the plan to the Governor and the Legislature by a specified date; specifying populations that are subject to such work and community engagement requirements; providing exceptions; defining the term "family caregiver"; specifying the types of activities which may satisfy the work and community engagement requirements; providing that a certain population is required to engage in work or community engagement activities only during standard school hours; requiring persons eligible for Medicaid to demonstrate compliance with the work and community engagement requirements at specified times as a condition of maintaining Medicaid

coverage; requiring the agency to develop a process for ensuring compliance with the work and community engagement requirements; requiring that such process align, to the extent possible, with certain existing processes; requiring the department to verify compliance with the work and community engagement requirements at specified intervals; requiring the agency, in coordination with the department, to conduct outreach regarding implementation of the work and community engagement requirements; specifying requirements for such outreach; specifying procedures in the event of noncompliance; requiring the agency, in coordination with the department, to notify a Medicaid recipient of a finding of noncompliance and the impact to eligibility for continued receipt of services; specifying requirements for such notice; amending s. 409.905, F.S.; deleting a requirement that the agency discontinue its hospital retrospective review program under certain circumstances; revising construction; requiring the agency to maintain cost-effective purchasing practices in its coverage of hospital inpatient services rendered to Medicaid recipients; amending s. 409.906, F.S.; requiring the agency to seek federal approval to implement a program for expanded coverage of home- and community-based behavioral health services for a specified population; specifying the goal of the program; requiring the agency to work in coordination with the department to develop the program; requiring the agency and the

department to develop certain estimates and submit them to the Legislature in a specified manner before the program may be implemented; amending s. 409.91195, F.S.; revising the purpose of the Medicaid Pharmaceutical and Therapeutics Committee to include creation of a Medicaid preferred physician-administered drug list, a Medicaid preferred product list, and a high-cost drug list; requiring the agency to adopt such lists upon recommendation of the committee; specifying the frequency with which the committee must review such lists for any recommended additions or deletions; specifying parameters for such recommended additions and deletions; providing that reimbursement for drugs not included on such lists is subject to prior authorization, with an exception; requiring the agency to publish and disseminate such lists to all Medicaid providers in the state by posting on the agency's website or in other media; providing requirements for public testimony related to proposed inclusions on or exclusions from certain lists; requiring the committee to consider certain factors when developing such recommended additions and deletions; amending s. 409.912, F.S.; revising the components of the Medicaid prescribed-drug spending-control program to include the preferred physician-administered drug list, the preferred product list, and the high-cost drug list; providing requirements for such lists; providing that the agency does not need to follow rulemaking procedures of ch. 120, F.S.,

when posting updates to such lists; establishing an alternative reimbursement methodology for long-acting injectables administered in a hospital facility setting for severe mental illness; requiring the agency to contract with a vendor to perform a fiscal impact study of the federal 340B Drug Pricing Program; providing requirements for the study; requiring specified entities to submit certain data to the agency for purposes of the study; providing that noncompliance with such requirement may result in sanctions from the agency or the Board of Pharmacy, as applicable; requiring the agency to submit the results of the study to the Governor and the Legislature by a specified date; providing construction; amending s. 409.913, F.S.; revising the definition of the term "overpayment"; providing that determinations of an overpayment under the Medicaid program may be based upon retrospective reviews, investigations, analyses, or audits conducted by the agency to determine possible fraud, abuse, overpayment, or recipient neglect; providing that certain notices may be provided using other common carriers, as well as through the United States Postal Service; creating s. 414.321, F.S.; requiring the department to limit eligibility for food assistance to individuals meeting specified criteria; requiring that food assistance recipients provide certain documentation for purposes of eligibility redeterminations; prohibiting the department from relying solely on an individual's

self-attestations to determine certain expenses; authorizing the department to adopt policies and procedures to accommodate certain applicants and recipients; creating s. 414.332, F.S.; requiring the department to develop and implement a food assistance payment accuracy improvement plan for a specified purpose; requiring the department to reduce the payment error rate to below a specified percentage; providing requirements for the plan; requiring the department to submit the plan to the Governor and the Legislature by a specified date; requiring the department, by a specified date, to submit quarterly progress reports of specified information to the Governor and the Legislature; providing for future repeal; amending s. 414.39, F.S.; requiring the department to require photographic identification on the front of electronic benefits transfer (EBT) cards, to the extent allowable under federal law; amending s. 414.455, F.S.; revising criteria for individuals required to participate in an employment and training program to receive food assistance from the Supplemental Nutrition Assistance Program; requiring the department to apply and comply with certain work requirements in accordance with federal law for food assistance; amending s. 409.91196, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Subsection (4) 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 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.

(4) A low-income person who meets all other requirements for Medicaid eligibility except citizenship and who is in need of emergency medical services. The eligibility of such a recipient is limited to the period of the emergency, in accordance with federal regulations. The agency may conduct retrospective reviews or audits of services rendered to the individual and claims submitted by the provider to validate the existence and duration of the emergency medical condition and whether the services rendered were necessary to treat the emergency medical condition, regardless of whether the provider obtained prior authorization for the services.

Section 2. Section 409.9041, Florida Statutes, is created to read:

409.9041 Medicaid work and community engagement requirements.—

(1) The Legislature finds that assisting able-bodied adult Medicaid recipients in achieving self-sufficiency through meaningful work and community engagement is essential to ensuring that the state Medicaid program remains a sustainable

resource for residents who are most in need of such assistance.

(2)(a) The agency shall seek federal approval to implement mandatory work and community engagement requirements for able-bodied adults, as specified in this section, as a condition of obtaining and maintaining coverage under the state Medicaid program. The agency may not implement the mandatory work and community engagement requirements until it receives federal approval through a Medicaid waiver and the agency's business plan submitted under paragraph (b) is specifically approved by the Legislature.

(b) The agency shall, in consultation with the Department of Children and Families and the Department of Commerce, develop a business plan to implement this section. The plan must include methods for determining Medicaid eligibility and the applicability of exemptions under subsections (3) and (4) on an ongoing basis and an analysis representing the potential effects that implementing this section will have on Medicaid enrollment and expenditures. The agency shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 1, 2026.

(3)(a) Medicaid recipients between the ages of 19 and 64 years, inclusive, must meet the work or community engagement requirements of this section, unless they are one of the following:

1. Indian as defined under 42 C.F.R. s. 438.14(a).

2. A parent, guardian, caretaker relative, or family caregiver of a dependent child younger than 14 years of age or of a disabled individual. For purposes of this paragraph, the term "family caregiver" means an adult family member or other

individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation.

3. Former foster youth younger than 26 years of age.

4. A veteran with a total disability, as specified under 38 C.F.R. s. 3.340 or as specified by a Veteran Affairs Disability Ratings Letter issued by the United States Department of Veterans Affairs.

5. An individual classified as medically frail under the Medicaid Institutionalized Care Program; categorized as aged, blind, or disabled under the state Medicaid program; or who has a developmental disability as defined in s. 393.063.

6. An individual living in a household that receives Supplemental Nutrition Assistance Program benefits and who is already in compliance with work requirements pursuant to s. 445.024.

7. An individual participating in a residential substance use treatment program.

8. An inmate of a public institution.

9. A woman eligible for Medicaid coverage in a pregnancy-related or postpartum care category.

(b) A person may satisfy the work or community engagement requirements of this section by participating in one or more of the following activities for at least 80 hours per month:

1. Paid employment.

2. On-the-job-training.

3. Vocational educational training.

4. Job skills training directly related to employment.

5. Education directly related to employment.

6. Satisfactory attendance at a secondary school or in a course of study leading to a high school equivalency diploma.

7. Enrollment at least half-time as defined in 34 C.F.R. s. 668.2(b) in a postsecondary education program to obtain a credential on the Master Credentials List as maintained pursuant to s. 445.004(6)(e).

8. Any other work activity designated as such by the Department of Commerce and provided by a local workforce development board pursuant to s. 445.024.

(c) Parents with children ages 14 through 18 are required to engage in work or community engagement activities only during standard school hours.

(4)(a) Notwithstanding any other statutory provision, in order to maintain Medicaid coverage, an eligible Medicaid recipient must, before enrollment and upon any redetermination for coverage, demonstrate compliance with the work or community engagement requirements of this section.

(b) The agency shall develop a process for ensuring compliance with this section which aligns, to the extent possible, with the processes currently in place relating to work and community engagement requirements authorized under the state's Supplemental Nutrition Assistance Program, including, but not limited to, participant registration with a local CareerSource center, employment and training programs, and collaboration with the state's local workforce boards.

(c) The department shall verify, in accordance with its procedures, that an individual subject to the work and community engagement requirements of this section demonstrates compliance

during the individual's regularly scheduled redetermination of eligibility and at least every 6 months thereafter.

(5) The agency, in coordination with the department, shall conduct outreach regarding the implementation of the work and community engagement requirements of this section. The outreach must include, at a minimum, notification to impacted individuals, including timelines for implementation, requirements for compliance, penalties for noncompliance, and information on how to request an exemption.

(6) If a recipient subject to the work and community engagement requirements of this section is determined to be in noncompliance with such requirements, the agency, in coordination with the department, must notify the recipient of the finding of noncompliance and the impact to his or her eligibility for continued receipt of Medicaid services. The notice must include, at a minimum, notification of all of the following:

(a) That the recipient is eligible for a grace period of 30 days to either come into compliance with the requirements or request an exemption from the requirements and that Medicaid coverage of services will continue during the grace period.

(b) That if, following the 30-day period, the individual has not come into compliance with or requested an exemption from the work and community engagement requirements, his or her application for assistance will be denied and services terminated at the end of the month following the month in which such 30-calendar-day period ends.

(c) The right of the individual to request a fair hearing if he or she is determined to be noncompliant with program

requirements and disenrolled from the state Medicaid program.

(d) The manner in which he or she can reapply for medical assistance under the state Medicaid program.

Section 3. Paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended, and paragraph (f) is added to that subsection, to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a)1. The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase.

2. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization.

3. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials.

4. ~~Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program. However,~~ This <u>paragraph</u> ~~subparagraph~~ may not be construed to prevent the agency from

conducting retrospective reviews under s. 409.913, including, but not limited to, reviews of prior-authorized claims and reviews in which an overpayment is suspected due to a mistake or submission of an improper claim or for other reasons that do not rise to the level of fraud or abuse.

(f) In its coverage of services under this subsection, the agency shall maintain cost-effective purchasing practices as required by s. 409.912.

Section 4. Present subsections (14) through (29) of section 409.906, Florida Statutes, are redesignated as subsections (15) through (30), respectively, and a new subsection (14) is added to that section, to read:

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

to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(14) HOME- AND COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES.—The agency shall seek federal approval to implement a program that covers an expanded array of home- and community-based services for adults 18 years of age and older diagnosed with a serious mental illness who are high utilizers of behavioral health services in an institutional setting. The program must be designed to reduce the need for institutional levels of care for adults with a serious mental illness. The agency shall work in coordination with the Department of Children and Families to develop the program. The agency and the department shall produce estimates of the program's potential costs to the Medicaid program and cost-savings for the department. Such estimates must be submitted to the Legislature as legislative budget requests and appropriated in the General Appropriations Act before the program may be implemented.

Section 5. Section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency for the purpose of developing a Medicaid preferred drug list, a Medicaid preferred physician-administered drug list, a Medicaid preferred product list, and a high-cost drug list.

(1) The committee shall be composed of 11 members appointed

by the Governor. Four members shall be physicians, licensed under chapter 458; one member licensed under chapter 459; five members shall be pharmacists licensed under chapter 465; and one member shall be a consumer representative. The members shall be appointed to serve for terms of 2 years from the date of their appointment. Members may be appointed to more than one term. The agency shall serve as staff for the committee and assist them with all ministerial duties. The Governor shall ensure that at least some of the members of the committee represent Medicaid participating physicians and pharmacies serving all segments and diversity of the Medicaid population, and have experience in either developing or practicing under a preferred drug list. At least one of the members shall represent the interests of pharmaceutical manufacturers.

(2) Committee members shall select a chairperson and a vice chairperson each year from the committee membership.

(3) The committee shall meet at least quarterly and may meet at other times at the discretion of the chairperson and members. The committee shall comply with rules adopted by the agency, including notice of any meeting of the committee pursuant to the requirements of the Administrative Procedure Act.

(4) Upon recommendation of the committee, the agency shall adopt a preferred drug list, a preferred physician-administered drug list, a preferred product list, and a high-cost drug list as described in s. 409.912(5). To the extent feasible, the committee shall review all drug or product classes included on the preferred drug list, the preferred physician-administered drug list, and the preferred product list every 12 months~~,~~ and

the high-cost drug list every 6 months. The committee may recommend additions to and deletions from the lists ~~preferred drug list~~, such that the lists provide ~~preferred drug list provides~~ for medically appropriate drug and product therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

(5) Except for antiretroviral drugs, reimbursement of drugs not included on the preferred drug list, preferred physician-administered drug list, preferred product list, or high-cost drug list is subject to prior authorization.

(6) The agency shall publish and disseminate the preferred drug list, preferred physician-administered drug list, preferred product list, and high-cost drug list to all Medicaid providers in the state by Internet posting on the agency's website or in other media.

(7) The committee shall ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter, have an opportunity to present public testimony to the committee with information or evidence supporting inclusion of a drug or product on the preferred drug list, preferred physician-administered drug list, or preferred product list. Such public testimony must ~~shall~~ occur before ~~prior to~~ any recommendations made by the committee for inclusion or exclusion from the preferred drug list, preferred physician-administered drug list, or preferred product list. Upon timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be

reviewed by the committee at the next regularly scheduled meeting following 3 months of distribution of the drug to the general public.

(8) The committee shall develop its preferred drug list, preferred physician-administered drug list, preferred product list, and high-cost drug list recommendations by considering the clinical efficacy, safety, and cost-effectiveness of a product.

(9) The Medicaid Pharmaceutical and Therapeutics Committee may also make recommendations to the agency regarding the prior authorization of any prescribed drug covered by Medicaid.

(10) Medicaid recipients may appeal agency preferred drug formulary decisions using the Medicaid fair hearing process administered by the Agency for Health Care Administration.

Section 6. Paragraph (a) of subsection (5) of section 409.912, Florida Statutes, is amended, and subsection (14) is added to that section, 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.

(5)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list and a Medicaid physician-administered drug list. The preferred drug list~~, which~~ shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion

of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The physician-administered drug list shall be a listing of physician-administered drugs covered by the state Medicaid program, based on the United States Food and Drug Administration's approved indications and compendia in 42 U.S.C. s. 1396r-8(g)(1)(B). Within the preferred physician-administered drug list, there must be a section containing a list of preferred physician-administered drugs that are cost-effective therapeutic options recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195. The physician-administered drug list must be updated at least twice a year. The agency may post and update the preferred drug list and the preferred physician-administered drug ~~updates to the~~ list on the agency's ~~an Internet~~ website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior authorization by telephone or other telecommunication device within 24 hours after receipt of a request for prior authorization; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. A Medicaid preferred product list, which shall be a listing of cost-effective therapeutic supplies recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each product class listed on the preferred product list and reimbursed by the state Medicaid program through the pharmacy point-of-sale. The agency may post the preferred product list and updates to the list on the agency's website without following the rulemaking procedures of chapter 120.

3. A list of high-cost drugs recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency, for the purpose of coverage, reimbursement, or billing guidance. The agency may post the high-cost drug list and updates to the list on the agency's website without following the rulemaking procedures of chapter 120.

4. A provider of prescribed drugs is reimbursed in an amount not to exceed the lesser of the actual acquisition cost based on the Centers for Medicare and Medicaid Services National Average Drug Acquisition Cost pricing files plus a professional dispensing fee, the wholesale acquisition cost plus a professional dispensing fee, the state maximum allowable cost plus a professional dispensing fee, or the usual and customary

charge billed by the provider.

5. A hospital facility administering long-acting injectables for severe mental illness shall be reimbursed separately from the diagnosis-related group. Long-acting injectables administered for severe mental illness in a hospital facility setting shall be reimbursed at no less than the actual acquisition cost of the drug.

6. The agency shall contract with a vendor to perform a detailed fiscal impact study to evaluate the 340B Drug Pricing Program administered by the Health Resources and Services Administration. The study must evaluate 340B compliance, 340B drug purchases, and reimbursement methodologies within the fee-for-service program and Statewide Medicaid Managed Care program. Statewide Medicaid Managed Care plans, pharmacy benefit managers, and Medicaid providers shall submit to the agency all data necessary for the completion of the study, including, but not limited to, information related to drug purchasing, reimbursement, billing and coding, and dispensing. Noncompliance with the 340B data submission requirements of this subparagraph may result in sanctions from the agency or the Board of Pharmacy, as applicable. The agency shall submit the results of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2027.

7.~~3.~~ The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical

necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

8.~~4.~~ The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

9.~~5.~~ The agency shall develop and implement a program that requires Medicaid practitioners who issue written prescriptions for medicinal drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by prescribers who issue written prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

10.~~6.~~ The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

11.~~7.~~ The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage guarantees a

manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency may contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers to implement this initiative.

12.a.~~8.a.~~ The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency may seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Families, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best

practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high

users of care.

13.~~9.~~ The agency shall implement a Medicaid prescription drug management system.

a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their

use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to recipients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

14.~~10.~~ The agency may contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

15.~~11.~~ The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

16.~~12.~~ The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior

authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's ~~Internet~~ website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

17.~~13.~~ The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

18.~~14.~~ The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug

product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease;

c. The drug product or medication of a similar drug class is prescribed for the treatment of schizophrenia or schizotypal or delusional disorders; prior authorization has been granted previously for the prescribed drug; and the medication was dispensed to the patient during the previous 12 months; or

d. Based on historical evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

19.~~15.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not

practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused.

(14) Neither this section nor this chapter prevents the agency from conducting retrospective reviews, investigations, analyses, audits, or any combination thereof to determine possible fraud, abuse, overpayment, or recipient neglect in the state Medicaid program pursuant to s. 409.913, including, but not limited to, reviews in which the services were the subject of a utilization review or prior authorization process.

Section 7. Paragraph (e) of subsection (1) and subsections (2) and (6) of section 409.913, Florida Statutes, are amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year.

The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the

report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program or that should not have been paid, including payments made ~~whether paid~~ as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake, and may include amounts paid for goods or services that were the subject of a utilization review or prior authorization process.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. An overpayment determination may be based upon retrospective reviews, investigations, analyses, audits, or any combination thereof to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program, regardless of whether a prior authorization was issued. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state

averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the mailing address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current mailing and service addresses ~~address~~. United States Postal Service or other common carrier's proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

Section 8. Section 414.321, Florida Statutes, is created to read:

414.321 Food assistance eligibility.—For purposes of eligibility determinations, the department shall:

(1) Limit eligibility to individuals who are residents of the United States and:

(a) Citizens or nationals of the United States;

(b) Aliens lawfully admitted for permanent residence as defined in the Immigration and Nationality Act, as amended;

(c) Aliens who have been granted the status of Cuban and Haitian entrant, as defined in the Refugee Education Assistance Act of 1980, as amended; or

(d) Individuals who lawfully reside in the United States in accordance with the Compacts of Free Association referred to in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(2) Require each applicant, or recipient for redetermination purposes, to provide documentation evidencing his or her shelter or utility expenses.

(a) The department is prohibited from relying solely on an individual's self-attestation in determining shelter or utility expenses.

(b) The department may adopt policies and procedures to accommodate an applicant or a recipient who, due to recent residency changes, is temporarily unable to furnish adequate documentation of shelter or utility expenses.

Section 9. Section 414.332, Florida Statutes, is created to read:

414.332 Food assistance payment accuracy plan.—

(1) The department shall develop and implement a comprehensive food assistance payment accuracy improvement plan to reduce the state's payment error rate. The department must reduce the payment error rate to below 6 percent. The plan must address the root causes of payment errors identified through an in-depth, data-driven analysis. The plan must include, but need

not be limited to, all of the following:

(a) Enhanced employee training and quality assurance.

1. The department shall administer standardized training for all economic self-sufficiency program staff at least annually. Training must, at a minimum, review the most common reasons for payment errors and methods for preventing such errors, and include pre- and post-training testing to measure staff proficiency.

2. The department shall establish a robust quality assurance review process that frequently reviews a statistically significant sample of cases before final benefit determination. This process must incorporate real-time, corrective feedback and on-the-job training for program staff and may not delay benefit determinations.

(b) Improvement in data sourcing. In contracting with entities providing data for verification of applicant and recipient information, the department shall maximize use of high quality automated data sources, including, but not limited to, comparing income and asset data with state, federal, and private sector data sources.

(2) By July 15, 2026, the department shall submit the food assistance payment accuracy improvement plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(3)(a) Beginning October 1, 2026, the department shall submit quarterly progress reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives detailing:

1. The state’s most recent official and preliminary food

assistance payment error rate.

2. A detailed breakdown of the most frequent and highest dollar value errors, including categorization by agency or client error and whether the error resulted in over- or under-payment.

3. Specific actions taken by the department under the food assistance payment accuracy improvement plan during the preceding quarter and data demonstrating the results of those actions.

4. A detailed plan to correct the most recently identified deficiencies.

(b) This subsection is repealed on October 1, 2028.

Section 10. Present subsections (6) through (11) of section 414.39, Florida Statutes, are redesignated as subsections (7) through (12), respectively, and a new subsection (6) is added to that section, to read:

414.39 Fraud.—

(6) The department shall require the use of photographic identification on the front of each newly issued and reissued electronic benefits transfer (EBT) card for each cardholder to the maximum extent allowed by federal laws and regulations.

Section 11. Subsection (2) of section 414.455, Florida Statutes, is amended to read:

414.455 Supplemental Nutrition Assistance Program; legislative authorization; mandatory participation in employment and training programs.—

(2) Unless prohibited by the Federal Government, the department must require a person who is receiving food assistance; who is 18 to 64 ~~59~~ years of age, inclusive; who does

not have children under the age of 14 ~~18~~ in his or her home; who does not qualify for an exemption; and who is determined by the department to be eligible, to participate in an employment and training program. The department shall apply and comply with exemptions from work requirements in accordance with applicable federal law.

Section 12. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

409.91196 Supplemental rebate agreements; public records and public meetings exemption.—

(1) The rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebate, and other trade secrets as defined in s. 688.002 that the agency has identified for use in negotiations, held by the Agency for Health Care Administration under s. 409.912(5)(a)11. ~~s. 409.912(5)(a)7.~~ are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 20, 2026

I respectfully request that **Senate Bill #1758**, relating to Public Assistance, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Don Gaetz
Florida Senate, District 1

File signed original with committee office

S-020 (03/2004)

Tab 8

The Florida Senate

APPEARANCE RECORD

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

2 February 2006
Meeting Date

Health Policy
Committee

1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Brian Meyer

Phone (850) 419-3456

Address 2727 Mahan Dr
Street

Tallahassee FL 32308
City State Zip

Email LegAffairs@AHCA.MyFlorida.com

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
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2/2/26
Meeting Date

Health Policy
Committee

SB 1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Aurelie Colon Larrauri

Phone 9548818595

Address 403 Washington Ave
Street

Email aurelie.colon@splcenter.org

Montgomery AL 36104
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: SPLC

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

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

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The Florida Senate

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2/2/26
Meeting Date

Health Policy
Committee

1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Karen Woodall

Phone 850-321-9386

Address 579 E. Call St.
Street

Email fcfep@yahoo.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:
National Latina Institute for Reproductive Justice
FL Center for Fiscal & Economic Policy

☐ 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

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2 Feb 26
Meeting Date

Health Policy
Committee

SB 1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Brenda Leon One Voice Coalition Phone (618) 699-6012

Address 8501 Laguna Cir
Street

Email ~~Aoothj~~ brenda@onevoicefl.com

Miccosukee Fl 32317
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)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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2/2/26	SB 1758
Meeting Date	Bill Number or Topic
Health Policy	
Committee	Amendment Barcode (if applicable)

Name Ashley Lyerly

Phone 205-968-2266

Address PO Box 43263
Street

Email Ashley.Lyerly@lung.org

Vestavia — AL — 35243-0263
City — *State* — *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
American Lung 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
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2 Feb 26
Meeting Date

Health Policy
Committee

SB [illegible] 1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Nicole Grabner

Phone (940) 867-7534

Address 850 Laguna Cir
Street

Email ngrabner04@gmail.com

Micco FL 32976
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

S-001 (08/10/2021)

2/2/26
Meeting Date

The Florida Senate

APPEARANCE RECORD

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

SB1758
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name ALISON HOLMES

Phone 407405-2210

Address 1620 RIDGE AVENUE
Street
LONGWOOD FL 32750
City State Zip

Email HOLMESABRAD@YAHOO.COM

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

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S-001 (08/10/2021)

2/2/26
Meeting Date

HEALTH POLICY
Committee

The Florida Senate

APPEARANCE RECORD

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SB 1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name JJ HOLMES

Phone 407-405-2210

Address 1620 RIDGE AVENUE
Street

Email JJ-HOLMES@HOTMAIL.COM

LONGWOOD FL 32750
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

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S-001 (08/10/2021)

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2/2/26
Meeting Date

HEALTH POLICY
Committee

1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Cindy Huddleston

Phone 407-440-1421 ext. 704

Address wk: 1001 N Orange Ave
Street

Email huddleston@floridapolicy.org

Orlando F: 32801
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

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☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

2/2/2026
Meeting Date

Health Policy
Committee

The Florida Senate

APPEARANCE RECORD

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

1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Melanie Andrade Williams

Phone

Address [redacted] Agnew Dr
Street

Tallahassee FL 32312
City State Zip

Email Williams@floridahealthjustice.org

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Health Justice Project

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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2/2/2026
Meeting Date

Senate Health Policy
Committee

SB 758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Acadia Jacob

Phone 754-999-0807

Address PO Box 743094
Street

Email acadia@healthyfla.org

Boynton Beach FL 33474
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

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2/2/26
Meeting Date

Health Policy
Committee

1758
Bill Number or Topic

Amendment Barcode (if applicable)

Name Susan Harbin

Phone 770-546-8845

Address
Street

Email Susan.harbin@cancer.org

City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
American Cancer Society
Cancer Action Network

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

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

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S-001 (08/10/2021)

CourtSmart Tag Report

Room: KB 412 **Case No.:** **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 2/2/2026 3:29:51 PM
Ends: 2/2/2026 6:05:33 PM Length: 02:35:43

3:30:01 PM The Committee on Health Policy will come to order
3:30:22 PM roll call - quorum present
3:31:08 PM tab 3 - SB 268 by Rodriguez
3:31:24 PM let's go straight to the strike-all amendment
3:32:09 PM Sen. Harrell recognized in questions
3:32:29 PM Sen. Berman recognized
3:33:09 PM Sen. Massullo
3:34:12 PM amendment adopted
3:34:16 PM on bill as amended
3:34:41 PM Dr. Shawn Patterson speaks for the bill
3:36:31 PM Katie Larson, representing Lee Health System, Inc, waives in support
3:36:36 PM Matthew Holliday, representing Naples Comprehensive Health, waives in support
3:36:40 PM Toni Large, representing Fla. College of Emergency Physicians, waives in support
3:36:47 PM Davide Mica, representing Fla. Hospital Assn., waives in support
3:37:35 PM SB 268 reported favorably as a CS
3:37:55 PM tab 5 - SB 514 by Osgood; bill introduced by sponsor
3:40:15 PM Sen. Harrell recognized in questions on the bill
3:42:34 PM barcode 199948 taken up
3:43:43 PM amendment adopted
3:44:01 PM Melanie Andrade Williams, representing Fla. Health Justice Project, speaks in favor
3:47:02 PM Cathy Timuta with Fla. Assn. of Healthy Start Coalitions waives in support
3:47:09 PM Barbara DeVane, representing Fla. NOW, waives in support
3:47:17 PM Karen Woodall, representing Nat'l Institute for Reproductive Justice, waives in support
3:47:23 PM Sen. Harrell in debate
3:48:50 PM Sen. Davis in debate
3:49:23 PM Sen. Berman recognized in debate
3:49:56 PM sponsor recognized to close
3:51:21 PM SB 514 reported favorably as a CS
3:51:38 PM tab 1 - SB 36 by Sen. Sharief
3:53:04 PM barcode 690594 taken up
3:53:42 PM amendment is adopted
3:54:08 PM Sen. Massullo recognized in questions on bill as amended
3:54:50 PM follow up question
3:58:27 PM Sen. Harrell in questions
4:02:43 PM back & forth
4:03:55 PM Sen. Passidomo in questions
4:04:49 PM Sen. Gaetz in questions
4:08:01 PM follow up by Gaetz
4:09:05 PM Dr. Sharon Rogers speaking in favor
4:11:07 PM Monica Barfield speaking in favor
4:14:47 PM Meredith Fischer waives in support
4:14:56 PM Erin Ballas, representing the Fla. Nurses Assn., waives in support
4:15:04 PM Allison Carvajal, representing Fla. Nurses Practitioner Network, waives in support
4:15:24 PM Fla. Assn. of Nurse Anesthesiology waives in support
4:15:35 PM Sen. Massullo in debate
4:17:41 PM Sen. Harrell in debate
4:18:51 PM Sen. Passidomo in debate
4:20:00 PM Sen. Leek in debate
4:20:32 PM Sen. Davis in debate
4:21:26 PM Sen. Osgood in debate
4:22:41 PM sponsor closes on bill
4:24:44 PM SB 36 reported favorably as a CS

4:24:58 PM tab 2 - SB 864 by Sharief
4:26:23 PM barcode 338936 taken up
4:27:00 PM amendment adopted
4:27:16 PM Sen. Harrell in questions on bill as amended
4:28:39 PM sponsor waives close
4:29:06 PM SB 864 reported favorably as a CS
4:29:25 PM tab 4 - SB 844 by Sen. Jones; bill introduced by sponsor
4:31:34 PM Sen. Massullo recognized in questions
4:32:38 PM Shamar Harper speaks in favor
4:35:04 PM Kemba Gosier speaks in favor
4:38:13 PM Naashon Ducille speaks in favor
4:41:43 PM Anthony Malcolm speaks in support
4:45:02 PM Kenley LaFrance speaks in favor
4:47:46 PM sponsor closes on bill
4:48:19 PM SB 844 reported favorably
4:48:20 PM Sen. Burton passes chair to Sen. Harrell
4:48:50 PM tab 6 - SB 1404 by Chair Burton
4:49:12 PM strike all 537686 amendment taken up
4:51:51 PM Jason Hand, representing Fla. Senior Living Assn., speaks in favor of the amendment
4:53:56 PM amendment adopted - on bill as amended
4:54:03 PM Karen Murrillo, representing AARP, waives in support
4:54:11 PM Tyler Jefferson, representing Alzheimer's Assn., waives in support
4:54:19 PM Brian Jogerst, representing the Elder Law section of the Fla. Bar, waives in support
4:54:53 PM sponsor waives close
4:55:19 PM SB 1404 reported favorably as a CS
4:55:32 PM chair turned back over to Chair Burton
4:55:51 PM tab 7 - SB 914 by Sen. Calatayud
4:56:33 PM barcode 507366 taken up
4:57:11 PM Corinne Mixon, representing Fla. Acupuncture Medical Assn., waives in support of amendment
4:57:25 PM amendment adopted
4:57:37 PM Anita Berry, representing Fla. Occupational Therapy Assn., waives in support of bill as amended
4:57:59 PM SB 914 reported favorably as a CS
4:58:18 PM tab 8 - SB 1758 by Gaetz
5:07:07 PM barcode 654120 taken up
5:07:26 PM substitute amendment barcode 498120 is taken up
5:07:53 PM sub. amendment adopted
5:08:10 PM barcode 838908 taken up
5:08:14 PM amendment adopted
5:08:23 PM barcode 822634 taken up
5:09:15 PM amendment adopted
5:09:22 PM on bill as amended
5:09:28 PM Sen. Harrell in questions
5:10:50 PM Sen. Berman in questions
5:19:30 PM Sen. Osgood in questions
5:22:45 PM Per Rule 2.10(2), the Sen. President has authorized the continuation of this meeting until complete
5:22:52 PM Sen. Davis in questions
5:25:29 PM Brian Meyer, LAD at AHCA, waives in support & for information
5:25:57 PM Acadia Jacob w/ Fla. Voices for Health speaks against the bill
5:27:25 PM Susan Harbin, representing Amer. Cancer Society & Cancer Action Network, speaks for information
5:29:33 PM Melanie Andrade Williams, representing Fla. Health Justice Project, speaks against
5:31:23 PM Cindy Huddleston w/ the Fla. Policy Institute speaks against
5:33:54 PM JJ Holmes speaks against
5:36:50 PM Alison Holmes speaks against
5:39:13 PM Nicole Grabner speaks against
5:41:45 PM Aurelie Colon Larrauri, representing SPLC, speaks against
5:43:31 PM Karen Woodall, representing Nat'l Institute for Reproductive Justice & the Center for Fiscally Economic Policy, speaks against
5:46:22 PM Brenda DeLeon w/ One Voice Coalition, speaks against
5:46:30 PM Ashley Lyerly, representing the Amer. Lung Assn., waives against
5:46:46 PM Sen. Berman recognized in debate
5:50:07 PM Sen. Harrell in debate
5:53:25 PM Sen. Passidomo in debate

5:55:26 PM Sen. Massullo in debate
5:57:20 PM sponsor closes on bill
6:04:13 PM SB 1758 reported favorably as a CS
6:04:31 PM Vote-After: Calatayud's affirmative on tabs 5 & 1
6:05:15 PM Vote-After: Sen. Davis tab affirmative for the ones she missed
6:05:23 PM meeting adjourned