Tab 8	**SB 688** by **Rodriguez;** Similar to H 00223 Naturopathic Medicine

Tab 9	**SB 1414** by **Polsky;** Identical to H 01203 Education on Congenital Cytomegalovirus

202186	A	S	HP, Polsky	Delete L.72 - 110.	02/06 04:37 PM

Tab 10	**SB 186** by **Garcia;** Similar to CS/H 01201 Student Health and Safety

333962	A	S	HP, Garcia	Delete L.61 - 64:	02/06 03:58 PM

Tab 11	**SB 902** by **Garcia;** Identical to H 00733 Department of Health

820828	A	S	HP, Garcia	Delete L.49 - 93.	02/06 04:19 PM
674674	A	S	HP, Garcia	btw L.345 - 346:	02/10 12:40 PM

Tab 12	**SB 196** by **Sharief (CO-INTRODUCERS) Osgood, Davis, Rouson, Bernard, Berman;** Identical to H 00327 Uterine Fibroid Research Database

514292	A	S	HP, Sharief	Delete L.17 - 24:	02/10 08:38 AM

Tab 13	**SB 1574** by **Bracy Davis (CO-INTRODUCERS) Sharief;** Similar to H 01335 Newborn Screenings

Tab 14	**SB 878** by **Yarborough;** Identical to H 01347 Clinical Laboratory Personnel

Tab 15	**SB 1092** by **Massullo;** Compare to CS/H 00567 Podiatric Medicine

455614	A	S	HP, Massullo	Delete L.87 - 216:	02/09 03:06 PM

Tab 16	**SB 1032** by **Calatayud;** Compare to H 00719 Medical Marijuana

956808	D	S	HP, Calatayud	Delete everything after	02/10 01:56 PM

Tab 17	**SB 1684** by **Calatayud;** Similar to CS/CS/H 01443 Parkinson’s Disease Registry

Tab 18	**SB 1686** by **Calatayud;** Similar to CS/H 01445 Public Records/Parkinson’s Disease Registry

438984	A	S	HP, Calatayud	Delete L.69:	02/06 03:57 PM

Tab 19	**SB 1760** by **Brodeur (CO-INTRODUCERS) Gaetz, Rouson;** Compare to H 00697 Health Care Coverage

620456	D	S	HP, Brodeur	Delete everything after	02/10 02:41 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Harrell, Vice Chair

MEETING DATE: Wednesday, February 11, 2026
TIME: 3:00—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	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION
	Senate Confirmation Hearing: A public hearing will be held for consideration of the below-named executive appointments to the offices indicated.		
	Secretary of Health Care Administration		
1	Harris, Shevaun ()	Pleasure of Governor	
	Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling		
2	Kraus, Tanya ()	10/31/2026	
	Reed, Stacey L. (Santa Rosa Beach)	10/31/2028	
	O'Brien, Alexandra L. (Tallahassee)	10/31/2028	
	Board of Dentistry		
3	Anderson, Marc ()	10/31/2029	
	White, Nicholas (Winter Park)	10/31/2029	
	Traverso, Elizabeth K. ()	10/31/2028	
	Marshall, Chadwick Justin (Fort Walton Beach)	10/31/2027	
	Mallah, Jessica (Odessa)	10/31/2026	
	Hill, Karyn (Parkland)	10/31/2029	
	Forrest, Andrew (Fort Lauderdale)	10/31/2028	
	Cherry, Bradley (Ponte Vedra Beach)	10/31/2027	
	Board of Medicine		
4	Balaji, Gobivenkata (Satellite Beach)	10/31/2026	
	Sargeant, Deborah A. (Gulf Stream)	10/31/2029	
	Littell, John (Ocala)	10/31/2028	
	Justice, Nicole (Valrico)	10/31/2028	
	Hunter, Patrick ()	10/31/2028	
	Gross, Lee (Port Charlotte)	10/31/2028	
	Diamond, David A. (Winter Park)	10/31/2029	
	Derick, Amy ()	10/31/2029	
	Board of Nursing		
5	Becker, Deborah (The Villages)	10/31/2027	
	Wolf, Lindsay (Julington Creek)	10/31/2028	

TAB	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION
	Wages, Jennifer (Panama City)	10/31/2029	
	Schafer, Patricia P. (Ocala)	10/31/2028	
	Roster, Fidelia Herrera (Palm Coast)	10/31/2028	
	Mueller, Christine (Sunrise)	10/31/2028	
	Board of Osteopathic Medicine		
6	Rooney, Derek Patrick, Jr. ()	10/31/2027	
	Reid-Paul, Theresa S. (Fort Lauderdale)	10/31/2028	
	Board of Pharmacy		
7	Hickman, Jonathan M. (Tallahassee)	10/31/2029	
	West, Stephen "Ryan" (Tallahassee)	10/31/2029	
	Mikhael, Mark W. (Seminole)	10/31/2028	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 688** Rodriguez (Similar H 223, Compare S 542)	Naturopathic Medicine; Creating the Board of Naturopathic Medicine within the Department of Health; prohibiting unlicensed persons from practicing naturopathic medicine or promoting, identifying, or describing themselves using specified titles or abbreviations; providing for licensure by examination of naturopathic doctors; providing for licensure by endorsement of naturopathic doctors; revising continuing education requirements for naturopathic doctors, etc. HP 02/11/2026 AHS FP	
9	**SB 1414** Polsky (Identical H 1203)	Education on Congenital Cytomegalovirus; Requiring the Department of Health, in consultation with medical experts identified by the department, to develop educational materials on congenital cytomegalovirus for distribution to expectant and new parents or caregivers; requiring certain hospitals, birth centers, and obstetrics and gynecology physician practices to provide the educational materials to such parents and caregivers; requiring the licensing boards of certain health care practitioners, beginning on a specified date, to require such practitioners to complete a board-approved course on congenital cytomegalovirus as a part of initial licensure and every other licensure renewal, etc. HP 02/11/2026 AHS FP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
10	**SB 186** Garcia (Similar CS/H 1201)	Student Health and Safety; Revising Department of Health responsibilities for educational programs concerning epilepsy; revising the definition of the term "school"; revising requirements for a student's individualized seizure action plan; revising the list of which employees must complete training in the care of students with epilepsy and seizure disorders, etc. HP 02/11/2026 ED RC	
11	**SB 902** Garcia (Identical H 733)	Department of Health; Defining the term "low-income"; deleting the definition of the term "medically underserved area"; revising requirements for department approval of qualified physicians and medical directors of medical marijuana treatment centers; prohibiting medical marijuana treatment center cultivating, processing, or dispensing facilities from being located within a specified distance of parks, child care facilities, or facilities providing early learning services; revising duties of the department in administering the Early Steps Program, etc. HP 02/11/2026 AHS RC	
12	**SB 196** Sharief (Identical H 327, Compare H 1515)	Uterine Fibroid Research Database; Requiring the Department of Health to include uterine fibroids in a specified list of diseases it issues; deleting a prohibition on the inclusion of personal identifying information in the database, etc. HP 02/11/2026 AHS FP	
13	**SB 1574** Bracy Davis (Similar H 1335)	Newborn Screenings; Citing this act as "Mattie's Law"; requiring that newborns, beginning on a specified date, be screened for biliary atresia; requiring the Department of Health to consult with the Genetics and Newborn Screening Advisory Council before adopting certain rules; requiring hospitals that provide birthing services to screen for biliary atresia in a specified manner, etc. HP 02/11/2026 AHS FP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
14	**SB 878** Yarborough (Identical H 1347)	Clinical Laboratory Personnel; Requiring that an applicant who qualifies for licensure under specified provisions provide proof of such qualification and pay the required fees to be eligible for licensure; requiring that applicants for licensure as a technologist or technician who meet specified criteria be deemed to have satisfied minimum qualifications for licensure to perform high or moderate complexity testing as a technologist or technician, as applicable, etc. HP 02/11/2026 AHS RC	
15	**SB 1092** Massullo (Compare CS/H 567)	Podiatric Medicine; Requiring certain podiatric physicians, instead of all podiatric physicians, to complete specified continuing education; authorizing podiatric physicians to perform stem cell therapy not approved by the United States Food and Drug Administration under certain circumstances; requiring podiatric physicians who perform such therapies to use stem cell therapy products obtained from facilities that adhere to applicable current good manufacturing practices, etc. HP 02/11/2026 AHS RC	
16	**SB 1032** Calatayud (Compare H 719)	Medical Marijuana; Increasing the number of supply limits of marijuana which a qualified physician may issue in a single physician certification for the medical use of marijuana; revising the frequency with which qualified physicians must evaluate existing qualified patients for a physician certification for the medical use of marijuana; revising the frequency with which qualified patient and caregiver identification cards must be renewed, from annually to biennially, etc. HP 02/11/2026 AHS AP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
17	**SB 1684** Calatayud (Similar CS/CS/H 1443, Compare CS/H 1445, Linked S 1686)	Parkinson's Disease Registry; Subject to a specific appropriation, requiring the Department of Health to contract with the Consortium for Parkinson's Disease Research within the University of South Florida for a specified purpose; beginning on a specified date, requiring physicians who diagnose or treat a patient with Parkinson's disease to report specified information to the registry; requiring physicians to notify patients orally and in writing of specified information before submitting reports to the registry; requiring the Parkinson's Disease Research Board to submit quarterly reports to the department, etc. HP 02/11/2026 AHS FP	
18	**SB 1686** Calatayud (Similar CS/H 1445, Compare CS/CS/H 1443, Linked S 1684)	Public Records/Parkinson's Disease Registry; Providing an exemption from public records requirements for certain records and personal identifying information submitted to the Parkinson's Disease Registry; providing for future legislative review and repeal; providing a statement of public necessity, etc. HP 02/11/2026 AHS FP	
19	**SB 1760** Brodeur (Compare H 697, H 1453, S 1158)	Health Care Coverage; Establishing the Joint Legislative Committee on Medicaid Oversight for specified purposes; revising encounter data reporting requirements for prepaid Medicaid plans; requiring managed care plans to report to the Agency for Health Care Administration and the Office of Insurance Regulation the existence of and specified details relating to certain affiliations by a specified date and annually thereafter; revising requirements for contracts between a pharmacy benefit manager and a pharmacy benefits plan or program and a participating pharmacy; revising and specifying additional practices pharmacy benefit managers are prohibited from engaging in, etc. HP 02/11/2026 AP	
	Other Related Meeting Documents		

35

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Shevaun L. Harris

is duly appointed

Secretary,
Agency for Health Care Administration

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

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

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

July 15, 2025

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

Dear Secretary Byrd:

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

Ms. Shevaun Harris
[redacted]

as Secretary of the Agency for Health Care Administration, subject to confirmation by the Senate. This appointment is effective July 15, 2025, for a term ending at the pleasure of the Governor.

Sincerely,

Ron DeSantis
Governor

RD/ch

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

HAND DELIVERED

RECEIVED
2025 OCT 28 PM 4:35
DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Leon

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

Secretary, Florida Agency for Health Care Administration

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 16th *day of* October, 2025.

_____

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

MARY CLEMMONS HAIRE
Commission # HH 351833
Expires February 25, 2027

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

[redacted]
Street or Post Office Box

[redacted]
City, State, Zip Code

Sheraun L. Harris
Print Name

_____
Signature

The Florida Senate

Committee Notice Of Hearing

IN THE FLORIDA SENATE
TALLAHASSEE, FLORIDA

IN RE: Executive Appointment of

Shevaun Harris

Secretary of Health Care Administration

NOTICE OF HEARING

TO: Secretary Shevaun Harris

YOU ARE HEREBY NOTIFIED that the Committee on Health Policy of the Florida Senate will conduct a hearing on your executive appointment on Wednesday, February 11, 2026, in the Pat Thomas Committee Room, 412 Knott Building, commencing at 3:00 p.m., pursuant to Rule 12.7(1) of the Rules of the Florida Senate.

Please be present at the time of the hearing.
DATED this the 9th day of February, 2026

Committee on Health Policy

Colleen Burton

Senator Colleen Burton
As Chair and by authority of the committee

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

220

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Tanya Kraus

is duly appointed a member of the

**Board of Clinical Social Work,
Marriage and Family Therapy,
and Mental Health Counseling**

for a term beginning on the Twenty-Second day of December, A.D., 2025, until the Thirty-First day of October, A.D., 2026 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fourth day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2025 DEC -6 AM 9:23

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 491.004, Florida Statutes:

Mrs. Tanya Kraus
[redacted]

as a member of the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2026.

Sincerely,

Ron DeSantis
Governor

RD/gc

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

RECEIVED

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes) 2026 FEB -4 AM 8:28

DIVISION OF ELECTIONS
TALLAHASSEE, FL

STATE OF FLORIDA
County of Broward

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

The board of clinical Social Work, Marriage, & family therapy and Mental heat Counseling
(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Tanya Kraus

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 26 *day of* JANUARY, 2026

Lauren B. Payne
Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

LAUREN B. PAYNE
Commission # HH 404333
Expires September 28, 2027

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

[redacted]

[redacted]
City, State, Zip Code

Tanya Kraus
Print Name

Tanya Kraus
Signature

220

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Stacey L. Reed

is duly appointed a member of the

**Board of Clinical Social Work,
Marriage and Family Therapy,
and Mental Health Counseling**

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Second day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2026 JAN -6 AM 9:23

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 491.004, Florida Statutes:

Ms. Stacey Reed
234 Loblolly Bay Drive
Santa Rosa Beach, Florida 32459

as a member of the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, filling a vacant seat previously occupied by Fabio Andrade, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/gc

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2026 JAN 20 PM 12:32

TALLAHASSEE, FL

STATE OF FLORIDA

County of Walton

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

Member, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Stacey L Reed

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 12 *day of* January, 2026.

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

NOTARY PUBLIC STATE OF FLORIDA

TONY RODRIGUEZ
Commission # HH 734652
Expires February 23, 2030

Personally Known ☐ *OR Produced Identification* ☒

Type of Identification Produced Drivers License

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

234 Loblolly Bay Drie
Street or Post Office Box

Santa Rosa Beach, FL 32459
City, State, Zip Code

Stacey L Reed
Print Name

Stacey L Reed
Signature

220

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Alexandra L. O'Brien

is duly appointed a member of the

**Board of Clinical Social Work,
Marriage and Family Therapy,
and Mental Health Counseling**

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Seventh day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2025 DEC -6 AM 9:24

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 491.004, Florida Statutes:

Ms. Alexandra O'Brien
811 Buena Vista Drive
Tallahassee, Florida 32304

as a member of the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, filling a vacant seat previously occupied by Jamie Buller, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/gc

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2026 JAN 23 AM 8:01

TALLAHASSEE, FL

STATE OF FLORIDA

County of Leon

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

Florida Board of Clinical Social Work Marriage and Family Therapy and Mental Health Counseling

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 22nd *day of* January, 2026.

_____

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

STEPHANIE TAFF
Notary Public
State of Florida
Comm# HH702305
Expires 7/24/2029

Personally Known ☐ *OR Produced Identification* ☒

Type of Identification Produced Florida license

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

811 Buena Vista Dr
Street or Post Office Box

Tallahassee, FL 32304
City, State, Zip Code

Alexandra OBrien
Print Name

_____
Signature

560

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Marc Anderson

is duly appointed a member of the

Board of Dentistry

for a term beginning on the Twenty-Second day of December, A.D., 2025, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fourth day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2026 JAN -6 AM 9:24

TALLAHASSEE, FL

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 466.004, Florida Statutes:

Dr. Marc Anderson
[redacted]

as a member of the Board of Dentistry, filling a vacant seat previously occupied by Tinerfe Tejera, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/gc

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2026 FEB -2 PM 2:47

STATE OF FLORIDA

County of Palm Beach

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

Florida Board of Dentistry

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature [redacted]

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐

this 31 *day of* January, 2026.

HUNTER JOHNSON
Notary Public - State of Florida
Commission # HH 685612
My Comm. Expires Jun 8, 2029

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)	*(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)*
Print Name	*Affix Seal Below*
Title	*Personally Known* ☐ *OR Produced Identification* ☑
Court	*Type of Identification Produced* FL DL

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

[redacted]

Street or Post Office Box

[redacted]

City, State, Zip Code

Marc Anderson

Print Name

[redacted]

Signature

560

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Nicholas White

is duly appointed a member of the

Board of Dentistry

for a term beginning on the Twenty-Second day of December, A.D., 2025, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Sixteenth day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2025 DEC -6 AM 9:24

DEPT OF STATE
TALLAHASSEE, FL

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 466.004, Florida Statutes:

Dr. Nicholas White
[redacted]

as a member of the Board of Dentistry, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/gc

OATH OF OFFICE

RECEIVED
DEPARTMENT OF STATE
2026 JAN 09 PM 1:31
DIVISION OF ELECTIONS
TALLAHASSEE, FL

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Orange

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

Florida Board of Dentistry

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Lisamarie Parker-Crisci

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 7th *day of* January, 2026

Lisamarie Parker Crisci

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

LISA MARIE PARKER-CRISCI
MY COMMISSION # HH 466761
EXPIRES: December 8, 2027

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced Driver License

ACCEPTANCE

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

Mailing Address: Home ☐ Office ☑

[redacted]

Street or Post Office Box

[redacted]

City, State, Zip Code

Nicholas White

Print Name

Signature

560

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Elizabeth K. Traverso

is duly appointed a member of the

Board of Dentistry

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Sixteenth day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2026 JAN -6 AM 9:24

TALLAHASSEE, FL

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 466.004, Florida Statutes:

Ms. Elizabeth Traverso
[redacted]

as a member of the Board of Dentistry, filling a vacant seat previously occupied by Fabio Andrade, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/gc

RECEIVED
2026 JAN -7 PM 2:09
DIVISION OF ELECTRICIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Pinellas

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

The Florida Board of Dentistry

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 5th *day of* January, 2026.

_____
Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

CHELSEA BERNHEIM
Commission # HH 619634
Expires December 9, 2028

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

[redacted]
Street or Post Office Box

[redacted]
City, State, Zip Code

Elizabeth Traverso
Print Name

_____
Signature

560

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Chadwick Justin Marshall

is duly appointed a member of the

Board of Dentistry

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Sixteenth day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 466.004, Florida Statutes:

Dr. Chadwick Marshall
304 Brooks Street Southeast
Fort Walton Beach, Florida 32548

as a member of the Board of Dentistry, succeeding Claudio Miro, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/dw

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2026 JAN 14 AM 8:48

STATE OF FLORIDA

County of Okaloosa

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

Florida Board of Dentistry

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 5th *day of* January, 20 26.

Alexis Hicks

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

ALEXIS HICKS
MY COMMISSION # HH 659382
EXPIRES: December 6, 2026

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

304 Brooks St SE
Street or Post Office Box

Fort Walton Beach, FL 32548
City, State, Zip Code

Chadwick Justin Marshall
Print Name

_____
Signature

560

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Jessica Mallah

is duly appointed a member of the

Board of Dentistry

for a term beginning on the Twenty-Second day of December, A.D., 2025, until the Thirty-First day of October, A.D., 2026 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Second day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2025 DEC -6 AM 9:24

TALLAHASSEE, FL

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 466.004, Florida Statutes:

Dr. Jessica Stilley-Mallah
5149 Deer Park Drive
New Port Richey, Florida 34653

as a member of the Board of Dentistry, filling a vacant seat previously occupied by Christine Bojaxhi, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2026.

Sincerely,

Ron DeSantis
Governor

RD/gc

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

RECEIVED
DEPARTMENT OF STATE
2026 JAN 20 PM 12:02
DIVISION OF ELECTIONS
TALLAHASSEE, FL

STATE OF FLORIDA
County of Hillsborough

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

Florida Board of Dentistry
(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Jessica Mallah

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 17 *day of* January, 2026

Bich Phuong Thu Nguyen
Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)
Affix Seal Below

BICH PHUONG THU NGUYEN
MY COMMISSION # HH 654225
EXPIRES: March 20, 2029

Personally Known ☐ *OR Produced Identification* ☑
Type of Identification Produced FL DL

ACCEPTANCE

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

Mailing Address: Home ☒ Office ☐

7206 North Mobley Rd
Street or Post Office Box

Odessa, FL 33556
City, State, Zip Code

Jessica Mallah
Print Name

Jessica Mallah
Signature

560

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Karyn Hill

is duly appointed a member of the

Board of Dentistry

for a term beginning on the Twenty-Second day of December, A.D., 2025, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Second day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2026 JAN -5 AM 9:24

TALLAHASSEE, FL

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 466.004, Florida Statutes:

Ms. Karyn Hill
7920 Northwest 84th Avenue
Parkland, Florida 33067

as a member of the Board of Dentistry, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/gc

RECEIVED
DEPARTMENT OF STATE
2026 JAN 28 AM 8:53
DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Broward

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

Board of Dentistry Member

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Karyn Hill

Sworn to and subscribed before me by means of physical presence ■ *OR online notarization* ☐
this 9 *day of* January, 20 26.

Ana Chacon

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

ANA CHACON
Notary Public - State of Florida
Commission # HH 655712
My Comm. Expires Mar 24, 2029
Bonded through National Notary Assn.

Personally Known ■ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

7920 NW 84th Ave
Street or Post Office Box

Parkland Fl 33067
City, State, Zip Code

Karyn Hill
Print Name

Karyn Hill
Signature

560

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Andrew Forrest

is duly appointed a member of the

Board of Dentistry

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Second day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2026 JAN -6 AM 9:24

TALLAHASSEE, FL

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 466.004, Florida Statutes:

Dr. Andrew Forrest
2612 Clematis Place
Fort Lauderdale, Florida 33301

as a member of the Board of Dentistry, succeeding Jose Mellado, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/dw

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

RECEIVED
2026 JAN 29 PM 3:22
ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF VIRGINIA

County of HAMPTON

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

Board of Dentistry

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature A. Forrest

Sworn to and subscribed before me by means of physical presence ☐ *OR online notarization* ☑
this 26th *day of* January, *20* 26.

Natasha A Stromley

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Natasha A Stromley
Electronic Notary Public
Commonwealth of Virginia
Registration No. 7678888
My Commission Expires 09/30/2028

Personally Known ☐ *OR Produced Identification* ☑

Type of Identification Produced Driver's License

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

2612 Clematis Place
Street or Post Office Box

Ft. Lauderdale, FL 33301
City, State, Zip Code

Andrew Forrest
Print Name

A. Forrest
Signature

560

STATE OF FLORIDA
DEPARTMENT OF STATE
Division of Elections

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

Bradley Cherry

is duly appointed a member of the

Board of Dentistry

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Sixteenth day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2026 JAN -6 AM 9:24

TALLAHASSEE, FL

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 466.004, Florida Statutes:

Dr. Bradley Cherry [redacted]

as a member of the Board of Dentistry, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/gc

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2026 JAN 14 AM 8:47

STATE OF FLORIDA

County of Saint Johns

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

Florida Board of Dentistry

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 6th *day of* January, 2026

_____

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

NOTARY PUBLIC STATE OF FLORIDA
SHADA HILLMAN
Notary Public - State of Florida
Commission # HH 449383
My Comm. Expires Sep 28, 2027

Personally Known ☐ *OR Produced Identification* ☒

Type of Identification Produced FL Drivers License

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

[redacted]
Street or Post Office Box

[redacted]
City, State, Zip Code

Bradley Cherry
Print Name

Signature

DS-DE 56 (Rev. 07/25)

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Gobivenkata Balaji

is duly appointed a member of the

Board of Medicine

for a term beginning on the Fourteenth day of November, A.D., 2025, until the Thirty-First day of October, A.D., 2026 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Third day of December, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

November 14, 2025

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

Dear Secretary Byrd:

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

Dr. Gobivenkata Balaji
340 Lanternback Island Drive
Satellite Beach, Florida 32937

as a member of the Board of Medicine, succeeding Zachariah Zachariah, subject to confirmation by the Senate. This appointment is effective November 14, 2025, for a term ending October 31, 2026.

Sincerely,

Ron DeSantis
Governor

RD/dw

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Brevard

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

Member, Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 18 *day of* November, 2025

MELINDA FARRELL
Notary Public - State of Florida
Commission # HH 455925
My Comm. Expires Oct 24, 2027
Bonded through National Notary Assn.

Melinda Farrell

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

MELINDA FARRELL
Notary Public - State of Florida
Commission # HH 455925
My Comm. Expires Oct 24, 2027
Bonded through National Notary Assn.

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced DL

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

340 Lanternback Island Dr
Street or Post Office Box

Satellite Beach FL 32937
City, State, Zip Code

Dr. Gobivenkata Balaji
Print Name

Signature

DS-DE 56 (Rev. 07/25)

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Deborah A. Sargeant

is duly appointed a member of the

Board of Medicine

for a term beginning on the Fourteenth day of November, A.D., 2025, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Third day of December, A.D., 2025

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

November 14, 2025

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

Dear Secretary Byrd:

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

Mrs. Deborah Sargeant
1420 North Ocean Boulevard
Gulf Stream, Florida 33483

as a member of the Board of Medicine, filling a vacant seat previously occupied by Maria Garcia, subject to confirmation by the Senate. This appointment is effective November 14, 2025, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/dw

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Palm Beach

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

Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Deborah A. Sargeant

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 16th *day of* December, 2025.

Michelle DeVeas

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)	*(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)*
	Affix Seal Below
	MICHELLE DEVEAS Commission # HH 430224 Expires August 6, 2027
Print Name	*Personally Known* ☐ *OR Produced Identification* ☐
Title	*Type of Identification Produced*
Court	

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

1420 N. Ocean Blvd,
Street or Post Office Box

Gulf Stream, Fl. 33483
City, State, Zip Code

Deborah A. Sargeant
Print Name

Deborah A Sargeant
Signature

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

John T. Littell

is duly appointed a member of the

Board of Medicine

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Third day of December, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

November 14, 2025

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

Dear Secretary Byrd:

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

Dr. John Littell
6619 Northwest 54th Loop
Ocala, Florida 34482

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

Sincerely,

Ron DeSantis
Governor

RD/dw

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2025 DEC 22 AM 8:49

STATE OF FLORIDA

County of MARION

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

Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 21st *day of* November, 2025.

_____

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name _____

Title _____

Court _____

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

SHELBY FORRET
Notary Public
State of Florida
Comm# HH631624
Expires 1/27/2029

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ☒ Office ☐

6619 NW 54th Loop
Street or Post Office Box

Ocala, FL 34482
City, State, Zip Code

John T. Littell
Print Name

_____
Signature

DS-DE 56 (Rev. 07/25)

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Nicole Justice

is duly appointed a member of the

Board of Medicine

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

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

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

November 14, 2025

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

Dear Secretary Byrd:

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

Ms. Nicole Justice
3017 Folklore Drive
Valrico, Florida 33596

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

Sincerely,

Ron DeSantis
Governor

RD/dw

OATH OF OFFICE

RECEIVED
DEPARTMENT OF STATE
2025 DEC 15 AM 11:28
DIVISION OF ELECTIONS
TALLAHASSEE, FL

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Hillsborough

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

Consumer Board Member, FL Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☐ *OR online notarization* ☑
this 12 *day of* December, *20* 25.

Lauren Argyris

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Notarized online using audio-video communication

ELECTRONIC NOTARY PUBLIC
STATE OF FLORIDA

Lauren Argyris
Electronic Notary Public
State of Florida
Commission #: HH565901
Commission Expires: 06/25/2028

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

3017 Folklore Drive
Street or Post Office Box

Valrico FL 33596
City, State, Zip Code

Nicole Justice
Print Name

Signature

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Patrick K. Hunter

is duly appointed a member of the

Board of Medicine

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Second day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

November 14, 2025

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

Dear Secretary Byrd:

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

Dr. Patrick Hunter
[redacted]

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

Sincerely,

Ron DeSantis
Governor

RD/dw

RECEIVED
2026 JAN 29 AM 11:02
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Santa Rosa

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

Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 26th *day of* January, 2026.

Sandra Perry

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

NOTARY PUBLIC STATE OF FLORIDA
SANDRA PERRY
MY COMMISSION # HH 608624
EXPIRES: November 3, 2028

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

[redacted]
Street or Post Office Box

[redacted]
City, State, Zip Code

Patrick K. Hunter
Print Name

Signature

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Lee Gross

is duly appointed a member of the

Board of Medicine

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Third day of December, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

November 14, 2025

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

Dear Secretary Byrd:

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

Dr. Lee Gross
132 Colonial Street Southwest
Port Charlotte, Florida 33952

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

Sincerely,

Ron DeSantis
Governor

RD/dw

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Charlotte

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

Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 16th *day of* December *20*25.

Michelle DeVeas

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

NOTARY PUBLIC STATE OF FLORIDA

MICHELLE DEVEAS
Commission # HH 430224
Expires August 6, 2027

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

132 Colonial Street SW
Street or Post Office Box

Port Charlotte, FL 33952
City, State, Zip Code

Lee Gross
Print Name

Signature

DS-DE 56 (Rev. 07/25)

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

David A. Diamond

is duly appointed a member of the

Board of Medicine

for a term beginning on the Fourteenth day of November, A.D., 2025, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

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

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

November 14, 2025

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

Dear Secretary Byrd:

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

Dr. David Diamond
[redacted]

as a member of the Board of Medicine, subject to confirmation by the Senate. This appointment is effective November 14, 2025, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/dw

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

RECEIVED
2025 NOV 21 PM 1:36
DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II, § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Orange

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

Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 19 *day of* November, 2025.

_____

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

XIMENA GOMEZ
Notary Public - State of Florida
Commission # HH 255591
My Comm. Expires Aug 13, 2026
Bonded through National Notary Assn.

Personally Known ☒ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

[redacted]
Street or Post Office Box

[redacted]
City, State, Zip Code

David A. Diamond
Print Name

_____
Signature

1535

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Amy Derick

is duly appointed a member of the

Board of Medicine

for a term beginning on the Fourteenth day of November, A.D., 2025, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

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

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

November 14, 2025

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

Dear Secretary Byrd:

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

Dr. Amy Derick
2590 Healing Way
Suite 220
Wesley Chapel, Florida 33543

as a member of the Board of Medicine, subject to confirmation by the Senate. This appointment is effective November 14, 2025, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/dw

RECEIVED
2025 DEC -4 PM 1:34
DIVISION OF ELECTIONS
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA
County of Miami Dade

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

Florida Board of Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Amy D MD

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 3rd *day of* December *20* 25

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Here

PAULA TELLES MARTINS
MY COMMISSION EXPIRES 03-13-2026
NOTARY PUBLIC
COMM. # HH 239781
STATE OF FLORIDA

Personally Known ☒ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

6873 Fisher Island Drive
Street or Post Office Box

Miami Beach, FL 33109
City, State, Zip Code

Amy Derick
Print Name

Amy D
Signature

1605

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Deborah Becker

is duly appointed a member of the

Board of Nursing

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Third day of December, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

December 12, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 464.004, Florida Statutes:

Dr. Deborah Becker
1486 Loris Loo
The Villages, Florida 32162

as a member of the Board of Nursing, subject to confirmation by the Senate. This appointment is effective December 12, 2025, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/dw

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2 PM 1:33

STATE OF FLORIDA

County of Sumter

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

Florida Board of Nursing - Registered Nurse Seat

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Deborah Becker

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 19th *day of* December, 20 25.

Notary Public

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

RYLEE J. KING
Notary Public - State of Florida
Commission # HH 655508
My Comm. Expires Mar 24, 2029

Personally Known ☐ *OR Produced Identification* ☒

Type of Identification Produced FL DL

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

1486 Loris Loop
Street or Post Office Box

The Villages, FL 32162
City, State, Zip Code

Deborah Becker
Print Name

Deborah Becker
Signature

1605

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Lindsay Wolf

is duly appointed a member of the

Board of Nursing

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Sixteenth day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2026 JAN -7 PM 12:58

December 30, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 464.004, Florida Statutes:

Dr. Lindsay Wolf
188 Ashlar Drive
St. Johns, Florida 32259

as a member of the Board of Nursing, succeeding Jose Castillo, subject to confirmation by the Senate. This appointment is effective December 30, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/dw

RECEIVED

2026 JAN 13 AM 11:42

TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Saint Johns

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

The Florida Board of Nursing

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Lindsay Wolf

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 7 *day of* January, 2026.

Stacie A. Butt

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

Notary Public State of Florida
Stacie A. Butt
My Commission HH 678769
Expires 9/5/2029

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

188 Ashlar Drive
Street or Post Office Box

Saint Johns, FL 32259
City, State, Zip Code

Lindsay Wolf
Print Name

Lindsay Wolf
Signature

1605

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Jennifer Ann Wages

is duly appointed a member of the

Board of Nursing

for a term beginning on the Twelfth day of December, A.D., 2025, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Second day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2025 DEC 19 AM 9:09

December 12, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 464.004, Florida Statutes:

Mrs. Jennifer Wages
2604 West 21st Street
Panama City, Florida 32405

as a member of the Board of Nursing, subject to confirmation by the Senate. This appointment is effective December 12, 2025, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/dw

RECEIVED

2026 FEB -2 AM 10: 15

FLORIDA DEPARTMENT OF HEALTH
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Bay

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

Florida Board of Nursing

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Jennifer Wages

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐ *this* 27th *day of* January, 2026.

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

BROOKE OWENS
Notary Public - State of Florida
Commission # HH 399813
My Comm. Expires May 19, 2027
Bonded through National Notary Assn.

Personally Known ☒ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ☐ Office ☐

1847 Florida Avenue
Street or Post Office Box

Panama City, FL 32405
City, State, Zip Code

Jennifer Wages
Print Name

Jennifer Wages
Signature

1605

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Patricia P. Schafer

is duly appointed a member of the

Board of Nursing

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Sixteenth day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2025 DEC 19 AM 10:09

TALLAHASSEE, FL

December 12, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 464.004, Florida Statutes:

Mrs. Patricia Schafer
2015 Southwest 43rd Place
Ocala, Florida 34471

as a member of the Board of Nursing, succeeding Diana Forst, subject to confirmation by the Senate. This appointment is effective December 12, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/dw

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Marion

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

Member, Florida Board of Nursing

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Patricia P. Schafer

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 23 *day of* December, 2025.

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

NOTARY PUBLIC STATE OF FLORIDA
Sean Walsh
Commission # HH 691382
Commission Expires 06-24-2029
Bonded Through - Cynanotary
Florida - Notary Public

Personally Known ☒ *OR Produced Identification* ☐

Type of Identification Produced N/A

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

2015 SW 43rd Place
Street or Post Office Box

Ocala, FL 34471
City, State, Zip Code

Patricia P. Schafer
Print Name

Patricia P. Schafer
Signature

1605

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Fidelia Herrera Roster

is duly appointed a member of the

Board of Nursing

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Sixteenth day of January, A.D., 2026

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

December 12, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 464.004, Florida Statutes:

Dr. Fidelia Roster
10 North Riverwalk Drive
Palm Coast, Florida 32137

as a member of the Board of Nursing, subject to confirmation by the Senate. This appointment is effective December 12, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/dw

RECEIVED

2026 JAN 15 AM 8:27

TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Flagler

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

Member of the Florida Board of Nursing

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Fidelia Herrera Roster

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 14th *day of* January, 2026

Marla Wilhite

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

MARLA WILHITE
MY COMMISSION # HH567658
EXPIRES: July 06, 2028

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

10 N. Riverwalk Drive
Street or Post Office Box

Palm Coast, FL 32137
City, State, Zip Code

Fidelia Herrera Roster
Print Name

Fidelia Herrera Roster
Signature

1605

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Christine Mueller

is duly appointed a member of the

Board of Nursing

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Third day of December, A.D., 2025.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

December 12, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 464.004, Florida Statutes:

Dr. Christine Mueller
8691 Northwest 24th Street
Sunrise, Florida 33322

as a member of the Board of Nursing, subject to confirmation by the Senate. This appointment is effective December 12, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/dw

RECEIVED

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2025 DEC 19 PM 1:45

DIVISION OF ELECTIONS
TALLAHASSEE, FL

STATE OF FLORIDA

County of Broward

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

Board of Nursing

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐
this 16 *day of* December, *20*25.

Dara Nyree Catanzaro

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

TARA NYREE CATANZARO
Notary Public - State of Florida
Commission # HH 469614
My Comm. Expires Dec 3, 2027
Bonded through National Notary Assn.

Personally Known ☐ *OR Produced Identification* ☒

Type of Identification Produced Driver's License

ACCEPTANCE

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

Mailing Address: Home ☒ Office ☐

8691 NW 24th Street
Street or Post Office Box

Sunrise, FL. 33322
City, State, Zip Code

Christine Mueller
Print Name

_____
Signature

1685

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Derek Patrick Rooney, Jr

is duly appointed a member of the

Board of Osteopathic Medicine

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Second day of January, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2025 DEC -6 AM 9:25

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 459.004, Florida Statutes:

Mr. Derek "Patrick" Rooney
[redacted]

as a member of the Board of Osteopathic Medicine, filling a vacant seat previously occupied by Christopher Creegan, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2027.

Sincerely,

Ron DeSantis
Governor

RD/gc

OATH OF OFFICE

2025 JAN 20 AM 9:16

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Charlotte

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

Florida Board of Osteopathic Medicine

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☐ *OR online notarization* ☐
this _____ day of _____, 20____.

See Attached

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)	*(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)* *Affix Seal Below*
_____ *Print Name*	*Personally Known* ☐ *OR Produced Identification* ☐
_____ *Title*	*Type of Identification Produced* _____
_____ *Court*	

ACCEPTANCE

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

Mailing Address: Home ☒ Office ☐

[redacted]

Street or Post Office Box

[redacted]

City, State, Zip Code

Derek Rooney

Print Name

Signature

DS-DE 56 (Rev. 07/25)

1685

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Theresa S. Reid-Paul

is duly appointed a member of the

Board of Osteopathic Medicine

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

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Sixteenth day of January, A.D., 2026

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

2025 DEC -5 AM 9:24

DEPARTMENT OF STATE
TALLAHASSEE, FL

December 22, 2025

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 459.004, Florida Statutes:

Ms. Terry Reid-Paul
15922 Rain Lilly Way
Westlake, Florida 33470

as a member of the Board of Osteopathic Medicine, succeeding Valerie Jackson, subject to confirmation by the Senate. This appointment is effective December 22, 2025, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/dw

RECEIVED
2026 JAN -5 PM 12:35
TALLAHASSEE, FL

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA
County of Palm Beach

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

Board of Osteopathic Medicine
(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Theresa Reid-Paul

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 29 *day of* December, 2025

S. Batchelor
Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

15922 Rain Lilly Way
Street or Post Office Box

Westlake, FL. 33470
City, State, Zip Code

Theresa S. Reid-Paul
Print Name

Theresa Reid-Paul
Signature

1725

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Jonathan M. Hickman

is duly appointed a member of the

Board of Pharmacy

for a term beginning on the Thirtieth day of January, A.D., 2026, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fourth day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

January 30, 2026

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 465.004, Florida Statutes:

Dr. Jonathan Hickman
8314 Inverness Drive
Tallahassee, Florida 32312

as a member of the Board of Pharmacy, subject to confirmation by the Senate. This appointment is effective January 30, 2026, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/ch

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of Leon

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

Florida Board of Pharmacy

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☒ *OR online notarization* ☐ *this* 31 *day of* Jan, 2026.

_____

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

_____
Print Name

_____
Title

_____
Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

NOTARY PUBLIC STATE OF FLORIDA
DAVID FIGUEROA
MY COMMISSION # HH 654821
EXPIRES: March 23, 2029

Personally Known ☐ *OR Produced Identification* ☑

Type of Identification Produced FLDL

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

8314 Inverness Dr
Street or Post Office Box

Tallahassee, Florida, 32312
City, State, Zip Code

Jonathan M Hickman
Print Name

Signature

1725

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Stephen "Ryan" West

is duly appointed a member of the

Board of Pharmacy

for a term beginning on the Thirtieth day of January, A.D., 2026, until the Thirty-First day of October, A.D., 2029 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fourth day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

January 30, 2026

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

Dear Secretary Byrd:

Please be advised I have made the following reappointment under the provisions of Section 465.004, Florida Statutes:

Mr. Stephen "Ryan" West
7628 Refuge Road
Tallahassee, Florida 32312

as a member of the Board of Pharmacy, subject to confirmation by the Senate. This appointment is effective January 30, 2026, for a term ending October 31, 2029.

Sincerely,

Ron DeSantis
Governor

RD/ch

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

HAND DELIVERED

OATH OF OFFICE

2026 FEB -3 PM 12:04

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

STATE OF FLORIDA

County of LEON

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

Board of Pharmacy

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature _____

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 3 *day of* February, 2026.

Amanda Miller

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)	*(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)*
Print Name	*Affix Seal Below*
Title	AMANDA MILLER Commission # HH 687273 Expires September 6, 2029
Court	*Personally Known* ☐ *OR Produced Identification* ☑ *Type of Identification Produced* FL DL

ACCEPTANCE

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

Mailing Address: Home ☑ Office ☐

7628 Refuge Road
Street or Post Office Box

Tallahassee, FL 32312
City, State, Zip Code

Stephen "Ryan" West
Print Name

Signature _____

1725

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

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

Mark Mikhael

is duly appointed a member of the

Board of Pharmacy

for a term beginning on the Thirtieth day of January, A.D., 2026, until the Thirty-First day of October, A.D., 2028 and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Fourth day of February, A.D., 2026.

Secretary of State

DSDE 99 (3/03)

RON DESANTIS
GOVERNOR

January 30, 2026

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

Dear Secretary Byrd:

Please be advised I have made the following appointment under the provisions of Section 465.004, Florida Statutes:

Dr. Mark Mikhael
306 North Sweetwater Cove Boulevard
Longwood, Florida 32779

as a member of the Board of Pharmacy, succeeding Parastou "Patty" Ghazvini, subject to confirmation by the Senate. This appointment is effective January 30, 2026, for a term ending October 31, 2028.

Sincerely,

Ron DeSantis
Governor

RD/ch

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

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.; § 92.50, Florida Statutes)

2026 FEB -3 AM 11:45

STATE OF FLORIDA

County of Seminole

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

Florida Board of Pharmacy Member

(Full Name of Office – Abbreviations Not Accepted)

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

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

Signature Mark Mikhael

Sworn to and subscribed before me by means of physical presence ☑ *OR online notarization* ☐
this 2 *day of* February, 2026.

George Neville

Signature of Officer Administering Oath or of Notary Public

(To be completed only by judges administering oath– see § 92.50, Florida Statutes.)

Print Name

Title

Court

(To be completed by officer administering oath, other than judges – see § 92.50, Florida Statutes.)

Affix Seal Below

GEORGE NEVILLE
Notary Public
State of Florida
Comm# HH305014
Expires 8/24/2026

Personally Known ☑ *OR Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

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

Mailing Address: Home ■ Office ☐

306 N Sweetwater Cove Blvd
Street or Post Office Box

Longwood, Florida, 32779
City, State, Zip Code

Mark Mikhael
Print Name

Mark Mikhael
Signature

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 688
INTRODUCER:	Senator Rodriguez
SUBJECT:	Naturopathic Medicine
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 688 reestablishes the licensure and regulation of naturopathic doctors in Florida by redesignating ch. 462, F.S., as "Naturopathic Medicine" and by updating the chapter's regulatory framework.

The bill creates the Board of Naturopathic Medicine to assist the Department of Health (DOH) with the regulation of naturopathic doctors. The bill establishes licensure by examination for applicants who hold a doctoral degree in naturopathic medicine, provides for licensure by endorsement through the MOBILE Act, sets biennial renewal and continuing education requirements, and applies standard disciplinary authority. The bill also prohibits unlicensed practice and protected-title misuse, while providing specified exceptions.

The bill defines the scope of naturopathic practice to include specified diagnostic and natural treatment modalities but expressly excludes prescriptive authority for legend drugs or prescription drugs, except as expressly provided for certain natural, nonpharmacologic substances.

The bill provides an effective date of December 31, 2026.

II. Present Situation:

Naturopathy

The term "naturopathy" was used in the late nineteenth century to refer to an emerging system of natural therapies and philosophy to treat disease. Naturopathic physicians diagnose, treat, and care for patients using a system of practice that bases treatment on natural laws governing the human body. These practitioners may provide treatment to patients using psychological, mechanical, and other means to purify, cleanse, and normalize human tissues for the preservation

and restoration of health. This may include the use of air, water, light, heat, earth, food and herb therapy, psychotherapy, electrotherapy, physiotherapy, minor surgery, and naturopathic manipulation. Naturopathic physicians are trained in standard medical sciences and in the use and interpretation of standard diagnostic instruments. Naturopathic medicine stresses a holistic approach to health care, which involves studying and working with the patient mentally and spiritually, as well as physically, and developing an understanding of the patient in the patient's chosen environment.

Florida Licensure and Regulation of Naturopathy

Naturopathy was initially recognized by the Legislature in the Medical Act of 1921,[1] which defined the practice of medicine and exempted naturopaths from the medical practice act. Naturopathic practitioners were first licensed in Florida in 1927.[2] Doctors of Naturopathy were required to observe state, county, and municipal regulations regarding the control of communicable diseases, the reporting of births and deaths, and all matters relating to the public health as was required of other "practitioners of the healing arts."

Between 1947 and 1954, legal cases were decided regarding the rights of naturopaths to prescribe narcotic drugs. The Circuit Court in Pinellas County held that practitioners of naturopathy had the right to prescribe narcotic drugs.[3] On appeal, the Florida Supreme Court affirmed the lower court's decision.[4]

In 1957, the Legislature abolished the Board of Naturopathic Examiners, significantly revised the regulation of naturopathy, and placed the regulation under the Florida State Board of Health.[5] Naturopaths were classified into three groups based on the length of time that the practitioner was licensed in the state. Under that law, those licensed less than two years could not renew their licenses; those licensed more than two years but less than 15 years could not prescribe medicine in any form; and those licensed more than 15 years could not prescribe narcotic drugs. The Florida Supreme Court held that the naturopathic laws, as amended by ch. 57-129, L.O.F., were unconstitutional and void.[6]

In 1959, the Legislature abolished the licensing authority for naturopathy.[7] Only those naturopathic practitioners licensed at that time who had been residents of Florida for two years prior to enactment of ch. 59-164, L.O.F., were authorized to renew their licenses.

---

[1] Chapter 8415, Laws of Fla.
[2] Chapter 12286, Laws of Fla.
[3] *In re: Complaint of Melser*, 32 So.2d 742 (Fla.1947). See also *State Department of Public Works v. Melser*, 69 So.2d 347 at 353 (Fla. 1954).
[4] *Id*. *See* also Attorney General Opinion 54-96 and s. 893.02(19), F.S., relating to controlled substances, which defines "practitioner" to include "… a naturopath licensed pursuant to chapter 462, F.S." In 1939, the 5th Circuit Fed. Ct. (which includes Louisiana, Mississippi, and Texas) interpreted the Federal Narcotic Drug Act which determined that a "naturopath" was not a "physician;" therefore, they were prohibited from prescribing narcotic drugs. The court determined that even under phytotherapy, they could not prescribe drugs. Perry v. Larson, 104 F.2d 728 (1939).
[5] Chapter 57-129, Laws of Fla.
[6] *See Eslin v. Collins*, 69 So.2d 347 (Fla. 1959).
[7] Chapter 59-164, Laws of Fla.

Currently, ch. 462, F.S., governs the practice of naturopathy within the DOH. The current practice act includes a wide variety of healing techniques but prohibits surgery, chiropractic medicine, and the practice of "materia medica," a term that includes the prescription of drugs.[8] Chapter 462, F.S., prohibits the issuance of a license to any person who was not practicing naturopathy in Florida as of July 1, 1959.[9] The chapter also authorizes the DOH to adopt rules to implement the regulation of naturopathic medicine including the establishment of fees.[10] Additionally, it provides procedures for naturopathic physicians licensed prior to 1959 to renew their license.[11]

At this time, there are zero naturopathic physicians licensed in Florida.[12]

Other State Licensure of Naturopathy[13]

The following 26 states or territories offer licensure or registration to naturopaths: Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Mexico, North Dakota, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Washington, Wisconsin, Puerto Rico, and the U.S. Virgin Islands.

Education Accreditation and Requirements

Naturopathic medical schools are accredited through the Council on Naturopathic Medical Education (CNME). The CNME is the only naturopathic education accrediting agency recognized by the U.S. Department of Education (USDOE). There are currently six accredited programs, with eight campuses in Arizona, California, Illinois, Oregon, Washington, Puerto Rico and Canada.

Before enrolling in an accredited naturopathic medical school, students must:

- Successfully complete standard pre-medical college courses including physics, math, several courses of chemistry and biology as well as the humanities and psychology;
- Graduate from an accredited baccalaureate program; and
- Apply to and be accepted into one of the CNME accredited Doctor of Naturopathic Medicine Programs.

---

[8] Section 462.01(1), F.S., "Natureopathy" and "Naturopathy" shall be construed as synonymous terms and mean the use and practice of psychological, mechanical, and material health sciences to aid in purifying, cleansing, and normalizing human tissues for the preservation or restoration of health, according to the fundamental principles of anatomy, physiology, and applied psychology, as may be required. Naturopathic practice employs, among other agencies, phytotherapy, dietetics, psychotherapy, suggestotherapy, hydrotherapy, zone therapy, biochemistry, external applications, electrotherapy, mechanotherapy, mechanical and electrical appliances, hygiene, first aid, sanitation, and heliotherapy; provided, however, that nothing in this chapter shall be held or construed to authorize any naturopathic physician licensed hereunder to practice materia medica or surgery or chiropractic medicine, nor shall the provisions of this law in any manner apply to or affect the practice of osteopathic medicine, chiropractic medicine, Christian Science, or any other treatment authorized and provided for by law for the cure or prevention of disease and ailments.

[9] Section 462.023, F.S

[10] *Id*.

[11] Section 462.16, F.S.

[12] Department of Health, *2024 House Bill 843 Legislative Bill Analysis* (Dec. 19, 2023) (on file with the Senate Committee on Health Policy).

[13] *Id*.

Naturopathic medical school is a four-year doctoral program that provides students with advanced study in clinical sciences and naturopathic therapeutic treatment modalities.

Examination

The North American Board of Naturopathic Examiners (NABNE) is recognized as the examining body for the Naturopathic Physicians Licensing Examination (NPLEX). NPLEX is the examination that graduates of one of the approved naturopathic medical colleges must pass before being eligible for licensure in any of the 26 United States jurisdictions and five Canadian provinces that license or register naturopaths.

The purpose of NABNE is to determine the eligibility of applicants to take the NPLEX, to administer the NPLEX to examinees, and to send exam results and transcripts to regulatory authorities. The institutions that regulate naturopathic medicine grant authority to NABNE to be the examining body for the naturopathic medical profession through their agreement to use the results of the NPLEX in their determination of a candidate's eligibility for licensure.

The NPLEX is an independent, nonprofit organization whose purpose is to prepare valid and reliable biomedical science examinations (Part I) that assess the readiness of students to enter the clinical phase of training, and clinical science examinations (Part II) that assess the entry-level competence of candidates who plan to become licensed naturopaths.

III. Effect of Proposed Changes:

Section 1 of the bill redesignates ch. 462, F.S., from "Naturopathy" to "Naturopathic Medicine."

Section 2 of the bill creates s. 462.001, F.S., to provide legislative findings and purpose, including legislative intent to modernize regulation related to naturopathy in Florida by ensuring that naturopathic medicine is practiced by licensed naturopathic doctors who meet specified education and training standards and are held accountable for safe practice. The current ch. 462, F.S., regulates naturopathic *physicians*. The bill provides for the licensure and regulation of naturopathic *doctors*.

Section 3 of the bill creates s. 462.002, F.S., to provide exceptions, specifying that ch. 462, F.S., does not apply to other duly licensed health care practitioners acting within their respective scopes of practice; certain students and residents practicing under direct supervision in specified accredited or recognized programs; certain out-of-jurisdiction naturopathic doctors performing procedures or demonstrations for educational purposes at board-approved continuing education programs; the practice of the religious tenets of any church; and the domestic administration of recognized family remedies.

The section also provides that ch. 462, F.S., does not prohibit certain persons from employing specified natural therapies in their occupations or from using certain descriptive terms, provided that the person does not use a protected title and does not misrepresent himself or herself as a person licensed under the chapter.

Section 4 of the bill renumbers and amends s. 462.01, F.S., as s. 462.003, F.S., to revise and provide definitions. The section defines "naturopathic doctor" as a person who is licensed to practice naturopathic medicine under ch. 462, F.S., and revises the definition of "naturopathic medicine" and "practice of naturopathic medicine" to include specified diagnostic, preventive, and treatment modalities, and to exclude specified activities and practices.

The bill defines "naturopathic medicine" and "the practice of naturopathic medicine" as the diagnosis, prevention, and treatment of physical or mental conditions by a licensed naturopathic doctor using modalities such as botanical and fungal extracts, clinical nutrition, counseling, dietary supplements, environmental medicine, homeopathy, imaging, lab testing, lifestyle medicine, natural substances, physical exams, and physical medicine, when consistent with CNME-accredited doctoral education and consistent with naturopathic principles and the naturopathic therapeutic order.

The bill expressly excludes from the scope of naturopathic medicine:
- Prescribing, dispensing, or administering legend drugs or prescription drugs, except as expressly authorized for certain natural, nonpharmacologic substances (e.g., vitamin B12);
- Surgery;
- Holding out as, or practicing as, any other licensed profession (e.g., an allopathic or osteopathic physician, dentist, nurse practitioner, physician assistant, chiropractor, physical therapist, acupuncturist, or midwife);
- The use of general anesthesia or spinal anesthesia;
- Administering ionizing radioactive substances;
- High-velocity spinal or joint manipulation, unless the naturopathic doctor is also licensed as a chiropractor or an osteopathic physician;
- Acupuncture, unless the naturopathic doctor is also licensed as an acupuncturist; and
- Labor and delivery management, unless the naturopathic doctor is also licensed as a midwife.

Section 5 of the bill creates s. 462.004, F.S., to create the Board of Naturopathic Medicine (Board) within the DOH. The section provides for board membership, appointment, and confirmation requirements, and provides that applicable provisions of ch. 456, F.S., relating to practitioner regulatory boards will apply to the Board. The Board is to be composed of seven members, including four naturopathic doctors, two physicians licensed under ch. 458 or 459, F.S., and one non-physician public member.

Section 6 of the bill renumbers and amends s. 462.023, F.S., as s. 462.005, F.S., to authorize the Board to adopt rules to implement ch. 462, F.S., as amended by this bill.

This section of the bill also eliminates the DOH's existing authority to establish and collect initial licensing fees from naturopathic physicians.

Section 7 of the bill creates s. 462.006, F.S., to prohibit unlicensed persons from practicing naturopathic medicine or from promoting, identifying, or describing themselves as a "doctor of naturopathic medicine" or a "naturopathic doctor" or use the corresponding abbreviations "N.D." or "N.M.D." A violation of this section would constitute a misdemeanor and be punishable as provided in s. 775.082 or s. 775.083, F.S.

This section works in conjunction with the exceptions created in the bill's new s. 462.002, F.S., as the enumerated exempt individuals would not be engaging in unlicensed practice.

Section 8 of the bill creates s. 462.007, F.S., to provide for licensure by examination of naturopathic doctors. To become licensed by examination, a person must apply on a form furnished by the DOH and the Board must certify that the applicant meets the following criteria:

- Is at least 21 years old.
- Holds a bachelor's degree from a:
  - U.S. accredited college/university (recognized by USDOE or CHEA), or
  - Canadian university that is a Universities Canada member, or
  - Foreign institution with board-approved credential evaluation showing equivalency (via a nationally recognized credential-evaluating agency; transcripts/syllabi/diplomas required).
- Holds a naturopathic doctoral degree from a program accredited by the Council on Naturopathic Medical Education (CNME).
- Is physically and mentally fit to practice.
- Is of good moral character.
- Submits fingerprints and pays costs for a criminal background check.
- Obtains a passing score on Part I - Biomedical Science Examination, Part II - Core Clinical Science Examination, and Part II - Clinical Elective Pharmacology Examination of the competency-based national Naturopathic Physician Licensing Examination administered by the North American Board of Naturopathic Examiners.

The bill requires the DOH and the Board to use an investigative process to ensure that applicants meet the applicable criteria, authorizes the State Surgeon General or his or her designee to issue a 90-day licensure delay under certain circumstances, provides construction, prohibits the Board from certifying certain applicants for licensure until completion of an investigation in another jurisdiction, and authorizes the Board to deny certification or certify with restrictions or for a probationary period if it determines that an applicant does not meet all licensure requirements.

Section 9 of the bill creates s. 462.008, F.S., to provide for licensure by endorsement of naturopathic doctors through the Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act in s. 456.0145, F.S.

Section 10 of the bill renumbers and amends s. 462.08, F.S., as s. 462.009, F.S., to update requirements for licensure renewal for naturopathic doctors. The bill requires the DOH to adopt rules establishing procedures for the biennial renewal of licenses under this chapter.

This section retains the existing language providing for a biennial licensure renewal fee, as determined by the DOH, but which may not exceed $1,000.

Section 11 of the bill renumbers and amends s. 462.18, F.S., to revise continuing education requirements for naturopathic doctors. Under the bill, the Board must require at least 60 hours of continuing education during each biennial renewal period. The bill requires the Board to approve organizations that accredit naturopathic continuing education providers, including the American

Association of Naturopathic Physicians and the North American Naturopathic Continuing Education Accreditation Council.

The bill requires naturopathic doctors to use the DOH's electronic continuing education tracking system to demonstrate compliance with continuing education requirements. The DOH notes that it would be required to work with the contracted continuing education vendor to establish this profession within the tracking system.[14]

Section 12 of the bill renumbers and amends s. 462.19, F.S., to revise provisions related to reactivation of inactive naturopathic doctor licenses and requires the Board to adopt rules.

Section 13 of the bill renumbers and amends s. 462.14, F.S., to revise grounds for disciplinary action. A naturopathic doctor would also be subject to grounds for discipline in s. 456.072, F.S.

Section 14 of the bill repeals s. 462.17, F.S., relating to the penalty for offenses relating to naturopathy.

Section 15 of the bill amends s. 20.43, F.S., to conform to changes made by the bill, including the Board within the DOH's Division of Medical Quality Assurance.

Section 16 of the bill amends s. 381.0031, F.S., to conform an existing provision that requires a practitioner licensed to practice naturopathy to report diseases of public health significance to the DOH, to changes made by the bill.

Section 17 of the bill amends s. 468.301, F.S., relating to radiological personnel certification, to conform to changes made by the bill.

Section 18 of the bill amends s. 476.044, F.S., exempting naturopathic physicians from barbering regulation, to conform to changes made by the bill.

Section 19 of the bill amends s. 477.0135, F.S., exempting naturopathic physicians from cosmetology regulation, to conform to changes made by the bill.

Section 20 of the bill amends s. 485.003, F.S., regarding hypnosis, to conform to changes made by the bill.

Section 21 of the bill amends s. 486.161, F.S., providing construction relating to the practice of physical therapy, to conform to changes made by the act.

Section 22 of the bill amends s. 627.351, F.S., relating to medical-malpractice shared-risk plans, to conform to changes made by the bill.

Section 23 of the bill amends s. 893.02, F.S., relating to drug abuse prevention and control, to replace a reference to a "naturopath" with "naturopathic doctor." *See Section VI. of this analysis, "Technical Deficiencies."*

[14] *Id*.

Section 24 of the bill amends s. 921.0022, F.S., to update the Criminal Punishment Code and conform to changes made by the bill. This section deletes "practicing naturopathy without a license" from the Criminal Punishment Code, as it is a misdemeanor and no longer a felony under the bill.

Section 25 of the bill provides an effective date of December 31, 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:

Section 6 of the bill, which renumbers and amends s. 462.023, F.S., as s. 462.005, F.S., eliminates the DOH's existing authority to establish and collect initial licensing fees from naturopathic physicians. The bill does not provide for the submission or collection of initial licensure fees.

Section 10 of the bill which renumbers and amends s. 462.08, F.S., as s. 462.009, F.S., retains the DOH's existing authority to establish and collect a biennial licensure renewal fee not to exceed $1,000.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOH and its Division of Medical Quality Assurance might experience a recurring increase in workload associated with processing applications for licensure, establishing the Board, and regulating naturopathic doctors. Because it is unclear how many applicants will seek initial licensure, the fiscal impact is indeterminate.

VI. Technical Deficiencies:

Section 23 of the bill amends s. 893.02, F.S., to update the title of a naturopathic doctor in accordance with changes made in the bill. However, because the bill does not include prescriptive authority in the scope of practice of naturopathic medicine, the reference to "a naturopath licensed under chapter 462" should be stricken and deleted rather than revised because the naturopathic doctor will not be authorized to prescribe controlled substances under the bill.

VII. Related Issues:

Section 5 of the bill creates s. 462.004, F.S., to require the appointment of four members of the Board who are "licensed naturopathic doctors who are residents of this state." The bill defines the term "naturopathic doctor" as a doctor licensed under ch. 462, F.S. It is unclear how initial appointments to the board can be made given that no individuals currently meet the criteria of being licensed naturopathic doctors.

The DOH has previously commented that it does not use a formal "investigative process" related to licensure applications and that MQA is not trained or staffed to conduct such investigations. The DOH notes that its current review process is efficient and effective in ensuring that applicants meet licensure requirements and do not pose a risk to health and safety of the public. If it is unintended for the DOH to establish an entirely new process for the licensure of naturopathic doctors, the bill should be amended to align with the licensure processes of other practitioners.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 20.43, 381.0031, 462.01, 462.003, 462.005, 462.08, 462.009, 462.18, 462.011, 462.19, 462.012, 462.14, 462.017, 462.023, 468.301, 476.044, 477.0135, 485.003, 486.161, 627.351, 893.02, 921.0022.

This bill creates the following sections of the Florida Statutes: 462.001, 462.002, 462.004, 462.006, 462.007, and 462.008.

This bill repeals section 462.17 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 Rodriguez

40-00433A-26 2026688__

A bill to be entitled

An act relating to naturopathic medicine; redesignating ch. 462, F.S., as "Naturopathic Medicine"; creating s. 462.001, F.S.; providing legislative findings and purpose; creating s. 462.002, F.S.; providing applicability and construction; renumbering and amending s. 462.01, F.S.; revising and providing definitions; creating s. 462.004, F.S.; creating the Board of Naturopathic Medicine within the Department of Health; providing for membership of the board; renumbering and amending s. 462.023, F.S.; authorizing the board to adopt rules; deleting obsolete language; creating s. 462.006, F.S.; prohibiting unlicensed persons from practicing naturopathic medicine or promoting, identifying, or describing themselves using specified titles or abbreviations; providing criminal penalties; creating s. 462.007, F.S.; providing for licensure by examination of naturopathic doctors; requiring the department and the board to use an investigative process to ensure that applicants meet the applicable criteria; authorizing the State Surgeon General or her or his designee to issue a 90-day licensure delay under certain circumstances; providing construction; prohibiting the board from certifying certain applicants for licensure until a certain investigation is completed; authorizing the board to take specified actions if it determines that an applicant does not meet all of the requirements for licensure; creating

s. 462.008, F.S.; providing for licensure by endorsement of naturopathic doctors; renumbering and amending s. 462.08, F.S.; revising requirements for licensure renewal for naturopathic doctors; requiring the department to adopt rules; renumbering and amending s. 462.18, F.S.; revising continuing education requirements for naturopathic doctors; requiring naturopathic doctors to use the department's electronic continuing education tracking system to demonstrate compliance with continuing education requirements; renumbering and amending s. 462.19, F.S.; revising provisions related to reactivation of inactive naturopathic doctor licenses; requiring the board to adopt rules; renumbering and amending s. 462.14, F.S.; revising grounds for disciplinary action; repealing s. 462.17, F.S., relating to penalty for offenses relating to naturopathy; amending ss. 20.43, 381.0031, 468.301, 476.044, 477.0135, 485.003, 486.161, 627.351, 893.02, and 921.0022, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Chapter 462, Florida Statutes, entitled "Naturopathy," is redesignated as "Naturopathic Medicine."

Section 2. Section 462.001, Florida Statutes, is created to read:

462.001 Legislative findings; purpose.—The Legislature

finds that the interest of public health requires modernization of regulation related to naturopathy in this state. Since 1927, when Florida first regulated naturopathy, the profession and its role in the health care industry have evolved, including the distinction that exists today between naturopathy and naturopathic medicine, and this chapter reflects that evolution. It is the intent of the Legislature to free naturopathy in this state by removing the near total ban on the profession that has been in place since 1959 by ensuring:

(1) Naturopathy is offered by naturopaths in this state.

(2) Naturopathic medicine is practiced in this state by issuing licenses to naturopathic doctors who meet clear standards of education and training and who are held accountable for safe practice.

Section 3. Section 462.002, Florida Statutes, is created to read:

462.002 Exceptions.—

(1) This chapter does not apply to:

(a) Other duly licensed health care practitioners acting within their respective scopes of practice, as authorized by general law.

(b) Students practicing under the direct supervision of a licensed naturopathic doctor as part of a preceptorship program while enrolled in a college or university program that is accredited by, or has candidacy status with, the Council on Naturopathic Medical Education or an equivalent accrediting body for the naturopathic medical profession which is recognized by the United States Department of Education and the board.

(c) Naturopathic residents practicing under the direct

supervision of a licensed naturopathic doctor at a residency site recognized by the Council on Naturopathic Medical Education or by an equivalent accrediting body for the naturopathic medical profession which is recognized by the United States Department of Education or the board.

(d) A naturopathic doctor who holds an active license in another jurisdiction of the United States or Canada and is performing naturopathic procedures or demonstrating equipment or supplies for educational purposes at a board-approved continuing education program.

(e) The practice of the religious tenets of any church in this state.

(f) The domestic administration of recognized family remedies.

(2) This chapter does not prohibit:

(a) A person who sells a dietary supplement from providing information about the dietary supplement.

(b) Any person:

1. Not licensed as a naturopathic doctor from employing in his or her occupation Ayurveda, herbalism, homeopathy, naturopathy as defined in s. 462.003, nutrition, traditional Chinese medicine, or other natural therapy included as part of the practice of naturopathic medicine, as defined in s. 462.003; or

2. From using terms, including, but not limited to, "certified naturopath," "naturopath," "naturopathy," "traditional naturopath," or "traditional naturopath," provided that the person does not:

a. Use a title protected under s. 462.006; or

b. Represent or assume the character or appearance of a person described in s. 462.006.

Section 4. Section 462.01, Florida Statutes, is renumbered as section 462.003, Florida Statutes, and amended to read:

462.003 ~~462.01~~ Definitions.—As used in this chapter, the term:

(1) "Board" means the Board of Naturopathic Medicine.

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

(3) "Naturopathic doctor" means a person who is licensed to practice naturopathic medicine under this chapter.

(4)(a) "Naturopathic medicine" and "practice of naturopathic medicine" mean the diagnosis, prevention, and treatment by a naturopathic doctor of any deformity, disease, injury, pain, or other physical or mental condition using botanical or fungal extracts, clinical nutrition, counseling techniques, dietary supplements, environmental medicine, homeopathic remedies, imaging studies, laboratory testing, lifestyle medicine, natural substances, physical exam, or physical medicine in a manner consistent with the education offered by naturopathic doctoral degree programs accredited by, or having candidacy status with, the Council on Naturopathic Medical Education or another accrediting agency recognized by the United States Department of Education or the board, and applied in a manner consistent with the principles of naturopathic medicine and the naturopathic therapeutic order defined herein.

(b) The term does not include any of the following:

1. Prescribing, dispensing, or administering any legend drug or prescription drug outside of natural, non-pharmacologic

substances, including, but not limited to, vitamin B12.

2. Performing any surgical procedure.

3. Practicing or claiming to practice as a medical doctor or physician, an osteopathic physician, a dentist, a podiatric physician, an optometrist, a psychologist, a nurse practitioner, a physician assistant, a chiropractic physician, a physical therapist, an acupuncturist, a midwife, or a health care practitioner as defined in s. 456.001.

4. Using general or spinal anesthetics.

5. Administering ionizing radioactive substances.

6. Performing chiropractic or osteopathic adjustments or manipulations that include high-velocity thrusts at or beyond the end range of normal joint motion, unless the naturopathic doctor is also licensed as a chiropractic physician or an osteopathic physician.

7. Performing acupuncture, unless the naturopathic doctor is also licensed as an acupuncturist.

8. Managing labor and delivery, unless the naturopathic doctor is also a licensed midwife.

(5) "Naturopathic therapeutic order" means a principle defined by the American Association of Naturopathic Physicians to guide naturopathic doctors in resolving a patient's symptoms and addressing the root cause of a patient's disease while using the least amount of therapeutic force necessary.

(6) ~~(1) "Naturopathy" and~~ "Naturopathy" is ~~shall be construed as~~ synonymous with "traditional naturopathy" and is understood to be distinct from naturopathic medicine, and means the traditional, noninvasive health practice offered by naturopaths and traditional naturopaths focusing on education

about natural practices and substances that can be used to promote general health and well-being ~~terms and mean the use and practice of psychological, mechanical, and material health sciences to aid in purifying, cleansing, and normalizing human tissues for the preservation or restoration of health, according to the fundamental principles of anatomy, physiology, and applied psychology, as may be required. Naturopathic practice employs, among other agencies, phytotherapy, dietetics, psychotherapy, suggestotherapy, hydrotherapy, zone therapy, biochemistry, external applications, electrotherapy, mechanotherapy, mechanical and electrical appliances, hygiene, first aid, sanitation, and heliotherapy; provided, however, that nothing in this chapter shall be held or construed to authorize any naturopathic physician licensed hereunder to practice materia medica or surgery or chiropractic medicine, nor shall the provisions of this law in any manner apply to or affect the practice of osteopathic medicine, chiropractic medicine, Christian Science, or any other treatment authorized and provided for by law for the cure or prevention of disease and ailments.~~

~~(2) "Department" means the Department of Health~~.

(7) "Principles of naturopathic medicine" means the foundations of naturopathic medical education and practice as set forth by the American Association of Naturopathic Physicians or the board and embodied in the education offered by naturopathic doctoral degree programs accredited by, or having candidacy status with, the Council on Naturopathic Medical Education or another accrediting agency recognized by the United States Department of Education or the board, and including all

of the following principles:

(a) The healing power of nature.

(b) Identify and treat the causes.

(c) First do no harm.

(d) Doctor as teacher.

(e) Treat the whole person.

(f) Prevention.

Section 5. Section 462.004, Florida Statutes, is created to read:

462.004 Board of Naturopathic Medicine.—

(1) There is created within the department the Board of Naturopathic Medicine, composed of seven members appointed by the Governor and confirmed by the Senate.

(2)(a) Four members of the board must be licensed naturopathic doctors who are residents of this state.

(b) Two members of the board must be physicians licensed under chapter 458 or chapter 459 who are residents of this state.

(c) One member of the board must be a resident of this state who is not, and has never been, licensed as a naturopathic doctor, an osteopathic physician, a physician, or any other closely related profession.

(d) At least one member of the board must be 60 years of age or older.

(3) As the terms of the members expire, the Governor shall appoint successors for terms of 4 years, and such members shall serve until their successors are appointed.

(4) All provisions of chapter 456 relating to the board shall apply.

Section 6. Section 462.023, Florida Statutes, is renumbered as section 462.005, Florida Statutes, and amended to read:

462.005 ~~462.023~~ Rulemaking authority; powers and duties of the board ~~department~~.—The board ~~department~~ may adopt ~~such~~ rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it ~~as are necessary to carry out the purposes of this chapter, initiate disciplinary action as provided by this chapter, and shall establish fees based on its estimates of the revenue required to administer this chapter but shall not exceed the fee amounts provided in this chapter. The department shall not adopt any rules which would cause any person who was not licensed in accordance with this chapter on July 1, 1959, and had not been a resident of the state for 2 years prior to such date, to become licensed~~.

Section 7. Section 462.006, Florida Statutes, is created to read:

462.006 License required.—

(1) Unless licensed under this chapter, a person may not practice naturopathic medicine in this state and may not promote, identify, or describe herself or himself as a "doctor of naturopathic medicine," or a "naturopathic doctor" or use the post-nominals "N.D." or "N.M.D."

(2) A person who violates this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 8. Section 462.007, Florida Statutes, is created to read:

462.007 Licensure by examination.—

(1) Any person desiring to be licensed as a naturopathic doctor must apply to the department on forms furnished by the department. The department shall license each applicant who completes the application form and who the board certifies has met all of the following criteria:

(a) Is at least 21 years of age.

(b) Has received a bachelor's degree from one of the following:

1. A college or university accredited by an accrediting agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or a successor entity recognized by the board;

2. A college or university in Canada which is a member of Universities Canada or a successor entity recognized by the board; or

3. A college or university in a foreign country, other than Canada, when such applicant has provided evidence that her or his educational credentials are deemed equivalent to those provided in this country or Canada. To have educational credentials deemed equivalent, the applicant must provide her or his foreign educational credentials, including transcripts, course descriptions or syllabi, and diplomas, to a nationally recognized educational credential evaluating agency approved by the board for the evaluation and determination of equivalency of the foreign educational credentials.

(c) Has received a naturopathic doctoral degree from a college or program accredited by, or having candidacy status with, the Council on Naturopathic Medical Education or another accrediting agency recognized by the United States Department of

Education or the board.

(d) Is physically and mentally fit to practice as a naturopathic doctor.

(e) Is of good moral character.

(f) Has submitted to the department a set of fingerprints on a form and in accordance with procedures specified by the department, along with payment in an amount equal to the costs incurred by the department for a criminal background check of the applicant.

(g) Has obtained a passing score on Part I - Biomedical Science Examination and Part II - Core Clinical Science Examination of the competency-based national Naturopathic Physician Licensing Examination administered by the North American Board of Naturopathic Examiners, or an equivalent examination offered by an equivalent or successor entity, as approved by the board.

(2) The department and the board shall ensure that applicants for licensure satisfy the applicable criteria in this section through an investigative process. If the investigative process is not completed within the timeframe established in s. 120.60(1) and the department or board has reason to believe that the applicant does not meet such criteria, the State Surgeon General or her or his designee may issue a 90-day licensure delay, which must be in writing and sufficient to notify the applicant of the reason for the delay. This subsection prevails over any conflicting provision of s. 120.60(1).

(3) The board may not certify to the department for licensure any applicant who is under investigation in another jurisdiction for an offense that would constitute a violation of

this chapter or chapter 456 until the investigation has been completed.

(4) If the board determines that an applicant for licensure has failed to meet, to the board's satisfaction, any of the requirements of this section, the board may take one of the following actions:

(a) Refuse to certify to the department an application for licensure.

(b) Certify to the department an application for licensure with restrictions on the scope of practice of the naturopathic doctor.

(c) Certify to the department an application for licensure with a probationary period for the applicant, subject to such conditions as the board specifies, including, but not limited to, requiring the naturopathic doctor to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another naturopathic doctor.

Section 9. Section 462.008, Florida Statutes, is created to read:

462.008 Licensure by endorsement.—The department shall issue a license to practice naturopathic medicine by endorsement to an applicant who, upon applying to the department on forms furnished by the department, the board certifies has met the requirements for licensure by endorsement under s. 456.0145.

Section 10. Section 462.08, Florida Statutes, is renumbered as section 462.009, Florida Statutes, and amended to read:

462.009 ~~462.08~~ Renewal of license to practice naturopathic medicine ~~naturopathy~~.—

(1) In order to continue practicing naturopathic medicine

in this state, each licensed naturopathic doctor must ~~licenseholder shall~~ biennially renew her or his license to practice naturopathic medicine ~~naturopathy~~. The applicant for license renewal must furnish to the board ~~department~~ such evidence as it requires of the applicant's compliance with s. 462.011 ~~s. 462.18~~, relating to continuing education ~~educational~~ requirements. The nonrefundable biennial renewal fee, the amount of which shall be determined by the department but which may not exceed $1,000, must be paid at the time the application for renewal of the license is filed.

(2) The department shall adopt rules establishing procedures for the biennial renewal of licenses under this chapter.

Section 11. Section 462.18, Florida Statutes, is renumbered as section 462.011, Florida Statutes, and amended to read:

462.011 ~~462.18~~ Continuing education ~~Educational~~ requirements.—

(1) At the time each licensee renews ~~shall renew~~ her or his license as ~~otherwise~~ provided in s. 462.009 ~~this chapter~~, each licensee must~~, in addition to the payment of the regular renewal fee, shall~~ furnish to the department satisfactory evidence that, in the preceding biennial period, the licensee has completed the continuing education requirements of this section.

(2) The board shall require each licensee to complete at least 60 hours of continuing education during each biennial renewal period.

(a) The board shall approve organizations that accredit naturopathic continuing education providers, including, but not limited to, the American Association of Naturopathic Physicians

and the North American Naturopathic Continuing Education Accreditation Council.

(b) The determination of whether substitute continuing education programs are permissible is solely within the discretion of the board.

(3) The licensee must use the electronic continuing education tracking system developed by the department under s. 456.0361 to demonstrate compliance with the continuing education requirements of this section ~~year preceding each such application for renewal, the licensee has attended the 2-day educational program as promulgated and conducted by the Florida Naturopathic Physicians Association, Inc., or, as a substitute therefor, the equivalent of that program as approved by the department. The department shall send a written notice to this effect to every person holding a valid license to practice naturopathy within this state at least 30 days prior to May 1 in each even-numbered year, directed to the last known address of such licensee, and shall enclose with the notice proper blank forms for application for annual license renewal. All of the details and requirements of the aforesaid educational program shall be adopted and prescribed by the department. In the event of national emergencies, or for sufficient reason, the department shall have the power to excuse the naturopathic physicians as a group or as individuals from taking this postgraduate course.~~

~~(2) The determination of whether a substitute annual educational program is necessary shall be solely within the discretion of the department~~.

Section 12. Section 462.19, Florida Statutes, is renumbered

as section 462.012, Florida Statutes, and amended to read:

462.012 ~~462.19~~ Renewal of license; inactive status; reactivation of license.—

(1) A licensee may reactivate an inactive license by applying to the department.

(2) The board shall adopt rules relating to the reactivation of licenses that have become inactive and the renewal of inactive licenses. The rules must include continuing education requirements as a condition for reactivating a license. The continuing education requirements for reactivating a license may not be fewer than 20 classroom hours for each year the license was inactive.

~~(1) The department shall renew a license upon receipt of the renewal application and fee.~~

~~(2) A licensee may request that her or his license be placed in an inactive status by making application to the department and paying a fee in an amount set by the department not to exceed $50~~.

Section 13. Section 462.14, Florida Statutes, is renumbered as section 462.017, Florida Statutes, and amended to read:

462.017 ~~462.14~~ Grounds for disciplinary action~~; action by the department~~.—

~~(1)~~ The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(1)~~(a)~~ Attempting to obtain, obtaining, or renewing a license to practice naturopathic medicine by bribery, by fraudulent misrepresentation, or through an error of the department.

(2)~~(b)~~ Having a license to practice naturopathic medicine

revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(3) ~~(c)~~ Being convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of naturopathic medicine or to the ability to practice naturopathic medicine. Any plea of nolo contendere shall be considered a conviction for purposes of this chapter.

(4) ~~(d)~~ False, deceptive, or misleading advertising related to the practice of naturopathic medicine.

(5) ~~(e)~~ Advertising, practicing, or attempting to practice under a name other than one's own.

(6) ~~(f)~~ Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department. However, a person who the licensee knows is unable to practice naturopathic medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

(7) ~~(g)~~ Aiding, assisting, procuring, employing, or advising any unlicensed person to practice naturopathic medicine contrary to this chapter or to a rule of the department.

(8) ~~(h)~~ Failing to perform any statutory or legal obligation placed upon a licensed naturopathic doctor ~~physician~~.

(9) ~~(i)~~ Making or filing a report which the licensee knows

to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the capacity as a licensed naturopathic doctor ~~physician~~.

~~(j) Paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. The provisions of This paragraph shall not be construed to prevent a naturopathic physician from receiving a fee for professional consultation services.~~

(10) ~~(k)~~ Exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity. A patient is ~~shall be~~ presumed to be incapable of giving free, full, and informed consent to sexual activity with her or his naturopathic doctor ~~physician~~.

~~(l) Making deceptive, untrue, or fraudulent representations in the practice of naturopathic medicine or employing a trick or scheme in the practice of naturopathic medicine when such scheme or trick fails to conform to the generally prevailing standards of treatment in the medical community.~~

~~(m) Soliciting patients, either personally or through an agent, through the use of fraud, intimidation, undue influence, or a form of overreaching or vexatious conduct. A "solicitation"~~

~~is any communication which directly or implicitly requests an immediate oral response from the recipient.~~

(11) ~~(n)~~ Failing to keep written medical records justifying the course of treatment of the patient~~, including, but not limited to, patient histories, examination results, test results, X rays, and records of the prescribing, dispensing and administering of drugs~~.

(12) ~~(o)~~ Exercising influence on the patient ~~or client~~ in such a manner as to exploit the patient ~~or client~~ for the financial gain of the licensee or of a third party~~, which shall include, but not be limited to, the promoting or selling of services, goods, appliances, or drugs and the promoting or advertising on any prescription form of a community pharmacy unless the form also states "This prescription may be filled at any pharmacy of your choice."~~

~~(p) Performing professional services which have not been duly authorized by the patient or client, or her or his legal representative, except as provided in s. 743.064, s. 766.103, or s. 768.13.~~

~~(q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the naturopathic physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the naturopathic physician's professional practice, without regard~~

~~to her or his intent.~~

~~(r) Prescribing, dispensing, or administering any medicinal drug appearing on any schedule set forth in chapter 893 by the naturopathic physician to herself or himself, except one prescribed, dispensed, or administered to the naturopathic physician by another practitioner authorized to prescribe, dispense, or administer medicinal drugs~~.

(13)~~(s)~~ Being unable to practice naturopathic medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, ~~the department shall have~~, upon a finding of the State Surgeon General or his or her designee that probable cause exists to believe that the licensee is unable to serve as a naturopathic doctor due to the reasons stated in this paragraph, the department shall have the authority to issue an order to compel the licensee~~, authority to compel a naturopathic physician~~ to submit to a mental or physical examination by a physician ~~physicians~~ designated by the department. If the licensee does not comply with such order, the department's order directing ~~failure of a naturopathic physician to submit to~~ such ~~an~~ examination may be enforced by filing a petition for enforcement in the circuit court for the county in which the naturopathic doctor resides or does business. The naturopathic doctor against whom the petition is filed may not be named or identified by initials in any public court record or document, and the proceedings must be closed to the public. The department is entitled to the summary procedure provided in s. 51.011 ~~when so directed shall constitute an admission of the allegations~~

~~against her or him upon which a default and final order may be entered without the taking of testimony or presentation of evidence, unless the failure was due to circumstances beyond the naturopathic physician's control~~. A naturopathic doctor subject to an order issued ~~physician affected~~ under this paragraph must, ~~shall~~ at reasonable intervals, be afforded an opportunity to demonstrate that she or he can resume the competent practice of naturopathic medicine with reasonable skill and safety to patients. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the department may be used against a naturopathic doctor ~~physician~~ in any other proceeding.

(14) ~~(t)~~ Gross or repeated malpractice or the failure to practice naturopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. ~~The department shall give great weight to the provisions of s. 766.102 when enforcing this paragraph.~~

~~(u) Performing any procedure or prescribing any therapy which, by the prevailing standards of medical practice in the community, constitutes experimentation on a human subject, without first obtaining full, informed, and written consent.~~

(15) ~~(v)~~ Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which the licensee knows or has reason to know ~~that~~ she or he is not competent to perform.

(16) ~~(w)~~ Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by

training, experience, or licensure to perform them.

(17) ~~(x)~~ Violating a lawful order of the board ~~the department~~ previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the board or department.

(18) ~~(y)~~ Conspiring with another licensee or with any other person to commit an act, or committing an act, which would tend to coerce, intimidate, or preclude another licensee from lawfully advertising her or his services.

(19) Fraud or deceit or gross negligence, incompetence, or misconduct in the operation of a course of study.

~~(z) Procuring, or aiding or abetting in the procuring of, an unlawful termination of pregnancy.~~

~~(aa) Presigning blank prescription forms.~~

~~(bb) Prescribing by the naturopathic physician for office use any medicinal drug appearing on Schedule II in chapter 893.~~

~~(cc) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug which is an amphetamine or sympathomimetic amine drug, or a compound designated pursuant to chapter 893 as a Schedule II controlled substance to or for any person except for:~~

~~1. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractability, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.~~

~~2. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.~~

~~3. The clinical investigation of the effects of such drugs or compounds when an investigative protocol therefor is submitted to, reviewed, and approved by the department before such investigation is begun.~~

~~(dd) Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. For the purposes of this subsection, the term "muscle building" does not include the treatment of injured muscle. A prescription written for the drug products listed above may be dispensed by the pharmacist with the presumption that the prescription is for legitimate medical use.~~

(20) Failing to comply with state, county, or municipal regulations or reporting requirements relating to public health and the control of contagious and infectious diseases.

(21) ~~(ee)~~ Violating any provision of this chapter or chapter 456, or any rule ~~rules~~ adopted pursuant thereto.

~~(2) The department may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).~~

~~(3) The department shall not reinstate the license of a naturopathic physician until such time as the department is satisfied that such person has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of naturopathic medicine.~~

~~(4) The department shall by rule establish guidelines for the disposition of disciplinary cases involving specific types of violations. Such guidelines may include minimum and maximum fines, periods of supervision or probation, or conditions of probation or reissuance of a license.~~

Section 14. Section 462.17, Florida Statutes, is repealed.

Section 15. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

20.43 Department of Health.—There is created a Department of Health.

(3) The following divisions of the Department of Health are established:

(g) Division of Medical Quality Assurance, which is responsible for the following boards and professions established within the division:

1. The Board of Acupuncture, created under chapter 457.

2. The Board of Medicine, created under chapter 458.

3. The Board of Osteopathic Medicine, created under chapter 459.

4. The Board of Chiropractic Medicine, created under chapter 460.

5. The Board of Podiatric Medicine, created under chapter 461.

6. The Board of Naturopathic Medicine ~~Naturopathy~~, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.

8. The Board of Nursing, created under part I of chapter 464.

9. Nursing assistants, as provided under part II of chapter

464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

16. Respiratory therapy, as provided under part V of chapter 468.

17. Dietetics and nutrition practice, as provided under part X of chapter 468.

18. The Board of Athletic Training, created under part XIII of chapter 468.

19. The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.

20. Electrolysis, as provided under chapter 478.

21. The Board of Massage Therapy, created under chapter 480.

22. The Board of Clinical Laboratory Personnel, created under part I of chapter 483.

23. Medical physicists, as provided under part II of chapter 483.

24. The Board of Opticianry, created under part I of chapter 484.

25. The Board of Hearing Aid Specialists, created under part II of chapter 484.

26. The Board of Physical Therapy Practice, created under chapter 486.

27. The Board of Psychology, created under chapter 490.

28. School psychologists, as provided under chapter 490.

29. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

30. Emergency medical technicians and paramedics, as provided under part III of chapter 401.

Section 16. Subsection (2) of section 381.0031, Florida Statutes, is amended to read:

381.0031 Epidemiological research; report of diseases of public health significance to department.—

(2) Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathic medicine ~~naturopathy~~, or veterinary medicine; any licensed pharmacist authorized under a protocol with a supervising physician under s. 465.1895, or a collaborative pharmacy practice agreement, as defined in s. 465.1865, to perform or order and evaluate laboratory and clinical tests; any hospital licensed under part I of chapter 395; or any laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder which diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health.

Section 17. Subsection (11) of section 468.301, Florida Statutes, is amended to read:

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

(11) "Licensed practitioner" means a person who is licensed or otherwise authorized by law to practice medicine, podiatric medicine, chiropody, osteopathic medicine, naturopathic medicine ~~naturopathy~~, or chiropractic medicine in this state.

Section 18. Subsection (1) of section 476.044, Florida Statutes, is amended to read:

476.044 Exemptions.—This chapter does not apply to the following persons when practicing pursuant to their professional responsibilities and duties:

(1) Persons authorized under the laws of this state to practice medicine, surgery, osteopathic medicine, chiropractic medicine, naturopathic medicine ~~naturopathy~~, or podiatric medicine;

Section 19. Paragraph (a) of subsection (1) of section 477.0135, Florida Statutes, is amended to read:

477.0135 Exemptions.—

(1) This chapter does not apply to the following persons when practicing pursuant to their professional or occupational responsibilities and duties:

(a) Persons authorized under the laws of this state to practice medicine, surgery, osteopathic medicine, chiropractic medicine, massage therapy, naturopathic medicine ~~naturopathy~~, or podiatric medicine.

Section 20. Subsections (2) and (3) of section 485.003, Florida Statutes, are amended to read:

485.003 Definitions.—In construing this chapter, the words, phrases, or terms, unless the context otherwise indicates, shall have the following meanings:

(2) "Healing arts" shall mean the practice of medicine, surgery, psychiatry, dentistry, osteopathic medicine, chiropractic medicine, naturopathic medicine ~~naturopathy~~, podiatric medicine, chiropody, psychology, clinical social work, marriage and family therapy, mental health counseling, and optometry.

(3) "Practitioner of the healing arts" shall mean a person licensed under the laws of the state to practice medicine, surgery, psychiatry, dentistry, osteopathic medicine, chiropractic medicine, naturopathic medicine ~~naturopathy~~, podiatric medicine, chiropody, psychology, clinical social work, marriage and family therapy, mental health counseling, or optometry within the scope of his or her professional training and competence and within the purview of the statutes applicable to his or her respective profession, and who may refer a patient for treatment by a qualified person, who shall employ hypnotic techniques under the supervision, direction, prescription, and responsibility of such referring practitioner.

Section 21. Subsection (1) of section 486.161, Florida Statutes, is amended to read:

486.161 Exemptions.—

(1) ~~No provision of~~ This chapter does not ~~shall be construed to~~ prohibit any person licensed in this state from using any physical agent as a part of, or incidental to, the lawful practice of her or his profession under the statutes applicable to the profession of chiropractic physician, podiatric physician, doctor of medicine, massage therapist, nurse, osteopathic physician or surgeon, occupational therapist, or naturopathic doctor ~~naturopath~~.

Section 22. Paragraph (h) of subsection (4) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(4) MEDICAL MALPRACTICE RISK APPORTIONMENT; ASSOCIATION CONTRACTS AND PURCHASES.—

(h) As used in this subsection:

1. "Health care provider" means hospitals licensed under chapter 395; physicians licensed under chapter 458; osteopathic physicians licensed under chapter 459; podiatric physicians licensed under chapter 461; dentists licensed under chapter 466; chiropractic physicians licensed under chapter 460; naturopathic doctors ~~naturopaths~~ licensed under chapter 462; nurses licensed under part I of chapter 464; midwives licensed under chapter 467; physician assistants licensed under chapter 458 or chapter 459; physical therapists and physical therapist assistants licensed under chapter 486; health maintenance organizations certificated under part I of chapter 641; ambulatory surgical centers licensed under chapter 395; other medical facilities as defined in subparagraph 2.; blood banks, plasma centers, industrial clinics, and renal dialysis facilities; or professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.

2. "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment, to which facility the patient is admitted and from which facility the patient is discharged within the same working day, and which facility is not part of a hospital. However, a facility existing

for the primary purpose of performing terminations of pregnancy or an office maintained by a physician or dentist for the practice of medicine may not be construed to be an "other medical facility."

3. "Health care facility" means any hospital licensed under chapter 395, health maintenance organization certificated under part I of chapter 641, ambulatory surgical center licensed under chapter 395, or other medical facility as defined in subparagraph 2.

Section 23. Subsection (23) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(23) "Practitioner" means a physician licensed under chapter 458, a dentist licensed under chapter 466, a veterinarian licensed under chapter 474, an osteopathic physician licensed under chapter 459, an advanced practice registered nurse licensed under chapter 464, a naturopathic doctor ~~naturopath~~ licensed under chapter 462, a certified optometrist licensed under chapter 463, a psychiatric nurse as defined in s. 394.455, a podiatric physician licensed under chapter 461, or a physician assistant licensed under chapter 458 or chapter 459, provided such practitioner holds a valid federal controlled substance registry number.

Section 24. Paragraph (g) of subsection (3) of section 921.0022, Florida Statutes, is amended to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.—

(3) OFFENSE SEVERITY RANKING CHART

(g) LEVEL 7

Florida Statute	Felony Degree	Description
316.027(2)(c)	1st	Accident involving death, failure to stop; leaving scene.
316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
316.1935(3)(b)	1st	Causing serious bodily injury or death to another person; driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.
327.35(3)(a)3.b.	3rd	Vessel BUI resulting in serious bodily injury.
402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration,

		permanent disability, or death.
409.920 (2)(b)1.a.	3rd	Medicaid provider fraud; $10,000 or less.
409.920 (2)(b)1.b.	2nd	Medicaid provider fraud; more than $10,000, but less than $50,000.
456.065(2)	3rd	Practicing a health care profession without a license.
456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
458.327(1)	3rd	Practicing medicine without a license.
459.013(1)	3rd	Practicing osteopathic medicine without a license.
460.411(1)	3rd	Practicing chiropractic medicine without a license.
461.012(1)	3rd	Practicing podiatric medicine without a license.

~~462.17~~	~~3rd~~	~~Practicing naturopathy without a license.~~
463.015(1)	3rd	Practicing optometry without a license.
464.016(1)	3rd	Practicing nursing without a license.
465.015(2)	3rd	Practicing pharmacy without a license.
466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
467.201	3rd	Practicing midwifery without a license.
468.366	3rd	Delivering respiratory care services without a license.
483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
483.901(7)	3rd	Practicing medical physics without a license.
484.013(1)(c)	3rd	Preparing or dispensing optical

		devices without a prescription.
484.053	3rd	Dispensing hearing aids without a license.
494.0018(2)	1st	Conviction of any violation of chapter 494 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.
560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding $300 but less than $20,000 by a money services business.
560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
775.21(10)(a)	3rd	Sexual predator; failure to

		register; failure to renew driver license or identification card; other registration violations.
775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
782.071	2nd	Killing of a human being or unborn child by the operation of a motor vehicle in a reckless manner (vehicular homicide).

782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
784.048(7)	3rd	Aggravated stalking; violation of court order.
784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.

784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
784.081(1)	1st	Aggravated battery on specified official or employee.
784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
784.083(1)	1st	Aggravated battery on code inspector.
787.025(2)(b)	2nd	Luring or enticing a child; second or subsequent offense.
787.025(2)(c)	2nd	Luring or enticing a child with a specified prior conviction.
787.06(3)(a)2.	1st	Human trafficking using coercion for labor and services of an adult.
787.06(3)(e)2.	1st	Human trafficking using coercion for labor and services by the transfer or transport of an adult from outside Florida to within the state.

790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
790.16(1)	1st	Discharge of a machine gun under specified circumstances.
790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
790.23	1st,PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided

		for in s. 874.04.
794.08(4)	3rd	Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim younger than 18 years of age.
796.05(1)	1st	Live on earnings of a prostitute; 2nd offense.
796.05(1)	1st	Live on earnings of a prostitute; 3rd and subsequent offense.
800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim younger than 12 years of age; offender younger than 18 years of age.
800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but younger than 16 years of age; offender 18 years of age or older.
800.04(5)(e)	1st	Lewd or lascivious molestation; victim 12 years of age or older but younger than 16 years;

		offender 18 years or older; prior conviction for specified sex offense.
806.01(2)	2nd	Maliciously damage structure by fire or explosive.
810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
810.02(3)(e)	2nd	Burglary of authorized emergency vehicle.
812.014(2)(a)1.	1st	Property stolen, valued at $100,000 or more or a semitrailer deployed by a law enforcement officer; property stolen while causing other property damage; 1st degree grand theft.

812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than $50,000, grand theft in 2nd degree.
812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
812.014(2)(b)4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.
812.014(2)(g)	2nd	Grand theft; second degree; firearm with previous conviction of s. 812.014(2)(c)5.
812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or more.
812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
812.131(2)(a)	2nd	Robbery by sudden snatching.
812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.

817.034(4)(a)1.	1st	Communications fraud, value greater than $50,000.
817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
817.234(9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
817.2341 (2)(b) & (3)(b)	1st	Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.
817.418(2)(a)	3rd	Offering for sale or advertising personal protective equipment with intent to defraud.
817.504(1)(a)	3rd	Offering or advertising a

		vaccine with intent to defraud.
817.535(2)(a)	3rd	Filing false lien or other unauthorized document.
817.611(2)(b)	2nd	Traffic in or possess 15 to 49 counterfeit credit cards or related documents.
825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
825.103(3)(b)	2nd	Exploiting an elderly person or disabled adult and property is valued at $10,000 or more, but less than $50,000.
827.03(2)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.
827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
827.071(2) & (3)	2nd	Use or induce a child in a sexual performance, or promote

		or direct such performance.
827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes child pornography.
837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
838.015	2nd	Bribery.
838.016	2nd	Unlawful compensation or reward for official behavior.
838.021(3)(a)	2nd	Unlawful harm to a public servant.
838.22	2nd	Bid tampering.
843.0855(2)	3rd	Impersonation of a public officer or employee.
843.0855(3)	3rd	Unlawful simulation of legal process.
843.0855(4)	3rd	Intimidation of a public officer or employee.

847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.
847.0135(4)	2nd	Traveling to meet a minor to commit an unlawful sex act.
872.06	2nd	Abuse of a dead human body.
874.05(2)(b)	1st	Encouraging or recruiting person under 13 to join a criminal gang; second or subsequent offense.
874.10	1st,PBL	Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related activity.
893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned

		recreational facility or community center.
893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5., within 1,000 feet of property used for religious services or a specified business site.
893.13(4)(a)	1st	Use or hire of minor; deliver to minor other controlled substance.
893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
893.135 (1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.
893.135 (1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.
893.135	1st	Trafficking in hydrocodone, 28

(1)(c)2.a.		grams or more, less than 50 grams.
893.135 (1)(c)2.b.	1st	Trafficking in hydrocodone, 50 grams or more, less than 100 grams.
893.135 (1)(c)3.a.	1st	Trafficking in oxycodone, 7 grams or more, less than 14 grams.
893.135 (1)(c)3.b.	1st	Trafficking in oxycodone, 14 grams or more, less than 25 grams.
893.135 (1)(c)4.b.(I)	1st	Trafficking in fentanyl, 4 grams or more, less than 14 grams.
893.135 (1)(d)1.a.	1st	Trafficking in phencyclidine, 28 grams or more, less than 200 grams.
893.135(1)(e)1.	1st	Trafficking in methaqualone, 200 grams or more, less than 5 kilograms.
893.135(1)(f)1.	1st	Trafficking in amphetamine, 14 grams or more, less than 28

		grams.
893.135 (1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
893.135 (1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
893.135 (1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
893.135 (1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.
893.135 (1)(m)2.a.	1st	Trafficking in synthetic cannabinoids, 280 grams or more, less than 500 grams.
893.135 (1)(m)2.b.	1st	Trafficking in synthetic cannabinoids, 500 grams or more, less than 1,000 grams.
893.135 (1)(n)2.a.	1st	Trafficking in n-benzyl phenethylamines, 14 grams or

		more, less than 100 grams.
893.1351(2)	2nd	Possession of place for trafficking in or manufacturing of controlled substance.
896.101(5)(a)	3rd	Money laundering, financial transactions exceeding $300 but less than $20,000.
896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.
943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.
943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.

943.0435(13)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.
944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.
944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification; providing false

		registration information.
985.4815(10)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
985.4815(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
985.4815(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.

Section 25. This act shall take effect December 31, 2026.

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 1414
INTRODUCER:	Senator Polsky
SUBJECT:	Education on Congenital Cytomegalovirus
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1414 requires additional training and the distribution of educational materials related to congenital cytomegalovirus (CMV).

The bill requires the Department of Health (DOH) to develop educational materials on CMV and specifies what must, at a minimum, be included in the materials. The educational materials must be distributed to expectant and new parents as part of any maternity, parental, or newborn services or education provided by a hospital, birth center, or obstetrics and gynecology (OB/GYN) physician practice in Florida, and the DOH must provide the educational materials to child care facilities and any other entity deemed relevant by the DOH.

Additionally, beginning July 1, 2026, the bill requires each applicable health care practitioner regulatory board governing allopathic and osteopathic medicine, nursing, and midwifery to require each licensed osteopathic or allopathic physician or physician assistant (PA), registered nurse (RN), licensed practical nurse (LPN), advanced practice registered nurse (APRN), and midwife to complete a one-hour continuing education (CE) course, approved by the applicable board, on CMV as a requirement for initial licensure and at every other licensure renewal. The bill specifies what each course must contain and allows for the course to count towards the number of hours required for any CE requirements the practitioner must complete as long as they are required to complete at least 30 CE hours. The bill specifies that failure to comply with the requirements of the section is grounds for disciplinary action. The bill also grants each applicable board rulemaking authority to implement the new CE requirements.

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

II. Present Situation:

Cytomegalovirus

Cytomegalovirus (CMV) is a common virus for people of all ages; however, a healthy person's immune system usually keeps the virus from causing illness.[1] In the United States, nearly one in three children are already infected with CMV by age five. Over half of adults have been infected with CMV by age 40. Once CMV is in a person's body, it stays there for life and can reactivate. A person can also be re-infected with a different strain (variety) of the virus. Most people with CMV infection have no symptoms and are not aware that they have been infected.[2]

A pregnant woman can pass CMV to her unborn baby. The virus in the woman's blood can cross through the placenta and infect the baby. This can happen when a pregnant woman is infected with CMV for the first time or is infected with CMV again during pregnancy.[3]

Some babies with congenital CMV infection have health problems that are apparent at birth or that develop later during infancy or childhood. In the most severe cases, CMV can cause the death of an unborn baby (pregnancy loss).

Some babies with congenital CMV infection have signs at birth. These signs include:
- Rash.
- Jaundice (yellowing of the skin or whites of the eyes).
- Microcephaly (small head).
- Low birth weight.
- Hepatosplenomegaly (enlarged liver and spleen).
- Seizures.
- Retinitis (damaged eye retina).

Some babies with signs of congenital CMV infection at birth may have long-term health problems, such as:
- Hearing loss.
- Developmental and motor delay.
- Vision loss.
- Microcephaly (small head).
- Seizures.

Some babies without signs of congenital CMV infection at birth may have hearing loss. Hearing loss may be present at birth or may develop later, even in babies who pass the newborn hearing test.[4]

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[1] About Cytomedalovirus (CMV), Centers for Disease Control and Prevention, available at About Cytomegalovirus | Cytomegalovirus (CMV) and Congenital CMV Infection | CDC (last visited Feb. 3, 2026).
[2] *Id.*
[3] Babies Born with Conginital Cytomegalovirus (CMV), Centers for Disease Control and Prevention, available at CMV in Newborns | Cytomegalovirus (CMV) and Congenital CMV Infection | CDC (last visited Feb. 3, 2026).
[4] *Id.*

CMV is the most common infectious cause of birth defects in the United States. About one out of 200 babies are born with congenital CMV. One out of five babies with congenital CMV will have symptoms or long-term health problems, such as hearing loss. Hearing loss may progress from mild to severe during the first two years of life, which is a critical period for language learning. Over time, hearing loss can affect a child's ability to develop communication, language, and social skills.

Babies who show signs of congenital CMV disease can be treated with medicines called antivirals. Antivirals may decrease the severity of hearing loss. Babies who get treated with antivirals should be closely monitored by their doctor because of possible side effects.[5]

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:
  - Physicians licensed under chs. 458 and 459, F.S., must complete a minimum of 40 hours of CE every two years of which the respective boards may require up to one hour be in the area of risk management or cost containment.[6]
  - PAs must 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.[7]
  - RNs, LPNs, and APRNs must 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.[8]
  - Midwives are require to complete 20 hours of CE of which one hour must be in HIV/AIDS,[9] one hour in laws and rules governing midwifery practice, and two hours must be in medical error prevention. Additionally, two hours of domestic violence training is required every third licensure renewal.[10]
- General CE requirements for health care practitioners include:
  - All practitioners licensed or certified by the DOH are required 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.[11]

[5] Congenital CMV and Hearing Loss, Centers for Disease Control and Prevention, available at Congenital CMV and Hearing Loss | Cytomegalovirus (CMV) and Congenital CMV Infection | CDC, (last visited Feb. 3, 2026).
[6] Section 456.013(6), F.S.
[7] Sections 458.347 and 459.022, F.S.
[8] Part I of ch. 464, F.S.
[9] Human immunodeficiency virus and acquired immunodeficiency syndrome.
[10] Section 467.012, F.S., and Rule 64B24-6.001, F.A.C.
[11] Section 456.013(7), F.S.,

- 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.[12]
- Persons licensed under multiple chapters of law, including physicians, nurses, and midwives to take CE courses on domestic violence, HIV and AIDS, and human trafficking.[13]

III. Effect of Proposed Changes:

Section 1 of the bill creates s. 383.142, F.S., to require the DOH to, in consultation with medical experts, develop educational materials on CMV to be distributed to expectant and new parents or caregivers as part of any maternity, prenatal, or newborn services or education provided by hospitals, birth centers, or OB/GYN physician practices in Florida. The materials must, at a minimum, include:

- The causes, symptoms, and effects of CMV infection and the ways it can be prevented. The materials must emphasize the fact that the virus can spread from person to person without detection and can be particularly dangerous if transmitted from a pregnant woman to her child as congenital CMV.
- The manner in which congenital CMV, if contracted, can lead to neurological issues, such as seizures, cerebral palsy, and developmental delays; sensory loss, such as hearing and vision loss; physical problems, such as low birth weight, jaundice, and enlarged liver and spleen; and, in severe cases, pregnancy loss. The materials must emphasize the importance of early testing for congenital CMV in newborns and infants to preserve their health and prevent lifelong health complications.
- The newborn, infant, and toddler hearing screening requirements in s. 383.145, F.S.

The bill requires each hospital, birth center, and OB/GYN physician practice in this state providing maternity, prenatal, or newborn services or education to provide the educational materials developed by the DOH under this section to expectant or new parents or caregivers receiving such services or education. The bill also requires the DOH to provide the educational materials to child care facilities and any other entity deemed relevant by the DOH.

Section 2 of the bill creates s. 456.0302, F.S., to require, beginning July 1, 2026, each applicable health care practitioner regulatory board for allopathic and osteopathic physicians and PAs, RNs, LPNs, APRNs, and midwives to require such practitioners to complete a board approved one-hour CE course on congenital CMV as part of initial licensure renewal and at every other biennial licensure renewal. The course must include:

- The causes, symptoms, and effects of CMV infection and the ways it can be prevented.
- The manner in which congenital CMV, if contracted, can lead to neurological issues, sensory loss, physical problems, and, in severe cases, pregnancy loss.
- The newborn, infant, and toddler hearing screening requirements of s. 383.145, F.S., and the importance of early testing for congenital CMV in newborns and infants to preserve their health and prevent lifelong health complications.

[12] Section 456.0301, F.S.
[13] Sections 456.031, 456.033, and 456.0341, F.S.,

Each practitioner must submit confirmation of having completed the CE course when submitting fees for every other licensure renewal and may count the one-hour course in their total hours of required CE as long as the practitioner is required to complete at least 30 hours of CE. A person holding two or more licenses required to take the course must only take the course only once. The bill specifies that failure to comply with the CE requirements is grounds for disciplinary action and, in addition to any discipline, the practitioner must be required to complete the course. Lastly, the bill grants each board rulemaking authority to implement the new CE requirements.

Section 3 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:

The bill may have an indeterminate negative fiscal impact on the DOH related to developing and distributing the required educational materials.

VI. Technical Deficiencies:

Section 2 of the bill requires specified boards to approve and require a CE course on congenital CMV "beginning July 1, 2026." However, the effective date of the bill is also July 1, 2026. Prior to the bill becoming effective, the boards will not have authority to adopt rules or approve such a course. It is unclear how the applicable boards will be able to approve and require a CE course immediately as the bill becomes effective. It may be advisable to move back the time for the requirement to give the applicable boards sufficient time to approve the new CE course and implement the requirement.

VII. Related Issues:

Section 2 of the bill refers to CE courses required and approved by the applicable boards for various practitioners. One practitioner type included in this requirement is midwifery; however, midwifery is not governed by a board, but rather by a council. Additionally, the council does not have rulemaking authority directly but rather is tasked with assisting and advising the DOH in developing rules.[14] Currently, the bill only grants rulemaking authority to "each board" to implement the CE requirements and does not grant rulemaking authority to the DOH as a whole or require the DOH to implement the requirement if there is no board. As such, it is unclear how the CE requirements in the bill would be implemented or enforced for midwives.

VIII. Statutes Affected:

This bill creates sections 383.142 and 456.0302 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.

[14] Section 467.004, F.S.

202186

LEGISLATIVE ACTION

Senate . House

. . . . . .

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

Senate Amendment (with title amendment)

Delete lines 72 - 110.

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

And the title is amended as follows:

Delete lines 14 - 31

and insert:

facilities; providing an

By Senator Polsky

30-01532B-26 20261414__

A bill to be entitled

An act relating to education on congenital cytomegalovirus; creating s. 383.142, F.S.; requiring the Department of Health, in consultation with medical experts identified by the department, to develop educational materials on congenital cytomegalovirus for distribution to expectant and new parents or caregivers; providing requirements for such educational materials; requiring certain hospitals, birth centers, and obstetrics and gynecology physician practices to provide the educational materials to such parents and caregivers; requiring the department to provide the educational materials to child care facilities; creating s. 456.0302, F.S.; requiring the licensing boards of certain health care practitioners, beginning on a specified date, to require such practitioners to complete a board-approved course on congenital cytomegalovirus as a part of initial licensure and every other licensure renewal; specifying requirements for the course; requiring such health care practitioners to submit confirmation of having completed the course in a specified manner; requiring the boards to include the hour required for completion of the course in the total hours of continuing education required for such profession, with an exception; authorizing a person holding two or more licenses subject to the continuing education requirement to show proof of completion of the course for purposes of relicensure for additional licenses;

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. Section 383.142, Florida Statutes, is created to read:

383.142 Education on congenital cytomegalovirus.—The Department of Health, in consultation with medical experts identified by the department, shall develop educational materials on congenital cytomegalovirus to be distributed to expectant and new parents or caregivers as part of any maternity, prenatal, or newborn services or education provided by hospitals, birth centers, or obstetrics and gynecology physician practices in this state.

(1) The educational materials must include, but need not be limited to, an explanation of all of the following:

(a) The causes, symptoms, and effects of cytomegalovirus infection and the ways it can be prevented. The materials must emphasize the fact that the virus can spread from person to person without detection and can be particularly dangerous if transmitted from a pregnant woman to her child as congenital cytomegalovirus.

(b) The manner in which congenital cytomegalovirus, if contracted, can lead to neurological issues, such as seizures, cerebral palsy, and developmental delays; sensory loss, such as hearing and vision loss; physical problems, such as low birth weight, jaundice, and enlarged liver and spleen; and, in severe

cases, pregnancy loss. The materials must emphasize the importance of early testing for congenital cytomegalovirus in newborns and infants to preserve their health and prevent lifelong health complications.

(c) The screening requirements of s. 383.145.

(2) Each hospital, birth center, and obstetrics and gynecology physician practice in this state providing maternity, prenatal, or newborn services or education shall provide the educational materials developed by the department under this section to expectant or new parents or caregivers receiving such services or education. The department shall provide the educational materials to child care facilities and any other entity deemed relevant by the department.

Section 2. Section 456.0302, Florida Statutes, is created to read:

456.0302 Requirement for instruction on congenital cytomegalovirus.—

(1) Beginning July 1, 2026, the applicable board shall require each person licensed under chapter 458, chapter 459, part I of chapter 464, or chapter 467 to complete a 1-hour continuing education course, approved by the board, on congenital cytomegalovirus as part of initial licensure and every other biennial licensure renewal. The approved course must include instruction on all of the following:

(a) The causes, symptoms, and effects of cytomegalovirus infection and the ways it can be prevented.

(b) The manner in which congenital cytomegalovirus, if contracted, can lead to neurological issues, sensory loss, physical problems, and, in severe cases, pregnancy loss.

(c) The screening requirements of s. 383.145 and the importance of early testing for congenital cytomegalovirus in newborns and infants to preserve their health and prevent lifelong health complications.

(2) Each such licensee must submit confirmation of having completed such course, on a form provided by the board, when submitting fees for every other biennial licensure renewal.

(3) Each board that requires a licensee to complete continuing education under this section shall include the hour 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.

(4) A person holding two or more licenses subject to this section may show proof of having completed one board-approved course on congenital cytomegalovirus for purposes of relicensure for additional licenses.

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

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

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

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 186
INTRODUCER:	Senator Garcia
SUBJECT:	Student Health and Safety
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown	HP	**Pre-meeting**
2.			ED	
3.			RC	

I. Summary:

SB 186 amends s. 1006.0626, F.S., within the Early Learning-20 Education Code, to modify current-law requirements for public schools to provide epilepsy or seizure disorder care to students.

The bill specifies that "school" includes a charter school under s. 1002.33, F.S., and provides that written orders from the student's physician or other medical professional regarding services to be provided by a school for a student who has epilepsy or a seizure disorder, may be in a form determined by the medical professional.

The bill also amends school employee training requirements within s. 1006.0626(3), F.S., to specify that the requirement for a school employee to complete training for the care of students with epilepsy and seizure disorders (if the employee's duties include regular contact with a student who has an individualized seizure action plan) applies to school *district* employees who meet that criterion (as opposed to "school employees" as under current law). The bill provides that such district employees include those who teach such students or transport them to and from school or school activities. The bill provides that the completion of such training is valid for five years.

The bill creates a new subsection (5) within s. 1006.0626, F.S., to require each public school to display a poster developed by the Department of Education which describes the basic steps of responding to an individual having a seizure.

Finally, the bill requires the Department of Health, as part of its current duties to institute and maintain an educational program among physicians, hospitals, county health departments, and the public concerning epilepsy, to include in that educational program the education and training requirements of s. 1006.0626(3) and (5), F.S., which pertain to public schools and school personnel.

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

II. Present Situation:

Epilepsy is a brain disorder that causes recurring seizures. Epilepsy affects people of all ages, but children and older adults are more likely to have epilepsy. Seizures are the main sign of epilepsy, and most people can control this with treatment. Seizure symptoms vary depending on the type of seizure. Because epilepsy is caused by certain brain activity, seizures can affect any brain process. Seizure symptoms may include:[1]

- Short-term confusion;
- A temporary catatonic state;
- Stiff muscles;
- Jerking movements of the arms and legs;
- Loss of consciousness; and/or
- Psychological symptoms such as fear, anxiety, or déjà vu.

In school settings, approximately six in 1,000 students have epilepsy. A U.S. Centers for Disease Control and Prevention study shows that students with epilepsy are likely to miss more days of school when compared to students who have other health issues, and students with epilepsy are more likely to have difficulties in their studies, use special education services, and have activity limitations such as less participation in sports or clubs.[2]

School Health Services Program

District school boards are responsible for attending to health, safety, and other matters relating to the welfare of students,[3] including the responsibility to establish emergency procedures for life-threatening emergencies.[4]

The Department of Health (DOH) has the responsibility, in cooperation with the Department of Education (DOE), to supervise the administration of the school health services program and perform periodic program reviews.[5] County health departments, district school boards, and local school health advisory committees[6] jointly develop school health services plans, which must include provisions for meeting emergency needs at each school.[7]

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[1] The Mayo Clinic, *Epilepsy,* available at: https://www.mayoclinic.org/diseases-conditions/epilepsy/symptoms-causes/syc-20350093 (last visited Jan. 31, 2026).
[2] Centers for Disease Control and Prevention, *Managing Epilepsy in Schools,* July 8, 2024, available at: https://www.cdc.gov/school-health-conditions/chronic/epilepsy.html (last visited Jan. 31, 2026).
[3] Section 1001.42(8)(a), F.S.
[4] Section 1006.062(6), F.S.
[5] Section 381.0056(3), F.S.
[6] Each school health advisory committee must include members who represent the eight component areas of the Coordinated School Health model as defined by the Centers for Disease Control and Prevention. *See* s. 381.0056(2)(b), F.S.
[7] Sections 381.0056(4)(a)12. and 1006.062(6), F.S.

The school health services plan describes the health services to be provided by a school.[8] For example, the plan must address:[9]

- Specified physical screenings.
- Health counseling.
- Meeting emergency health needs in each school.
- Consultation with a student's parent or guardian regarding the need for health attention by the family physician, dentist, or other specialist when definitive diagnosis or treatment is indicated.
- Maintenance of records on incidents of health problems, corrective measures taken, and such other information as may be needed to plan and evaluate health programs.

In attending to student health, the district school board is required to:[10]

- Provide in-service health training for school personnel;
- Make available adequate physical facilities for health services;
- At the beginning of each school year, inform parents or guardians in writing that their children who are students in the district schools will receive specified health services as provided for in the district health services plan. A student will be exempt from any of these services if his or her parent or guardian requests such exemption in writing.

In the absence of negligence, no person is liable for any injury caused by an act or omission in the administration of school health services.[11]

The Provision of Medical Services by School Board Personnel

All employees who staff school health rooms must be currently certified in first aid and cardiopulmonary resuscitation (CPR).[12] Additionally, each school must ensure that at least two school staff members and all school bus operators and attendants are currently certified to provide first aid and CPR.[13] School bus operators and attendants must also receive CPR and first aid refresher in-service training at least biennially.[14]

Nonmedical assistive personnel may perform health-related services upon successful completion of child-specific training by authorized licensed health care personnel.[15] All procedures must be monitored periodically by a nurse, advanced practice registered nurse, physician assistant, or physician, and may include administering emergency injectable medication.[16] Except for certain invasive procedures prohibited by law,[17] whether nonmedical district school board personnel

[8] Section 381.0056(2)(e), F.S.
[9] Section 381.0056(4)(a), F.S.
[10] Section 381.0056(6), F.S.
[11] Section 381.0056(8), F.S.
[12] Rule 64F-6.004(2), F.A.C.
[13] Rule 64F-6.004, F.A.C.; Rule 6A-3.0121(2)(b)3., F.A.C.
[14] Rule 6A-3.0121(2)(b)3., F.A.C.
[15] Section 1006.062(4), F.S. Authorized personnel include only a registered nurse or advanced practice registered nurse licensed under chapter 464, F.S., or a physician or physician assistant licensed under chapter 458 or chapter 459, F.S.
[16] Section 1006.062(4), F.S.
[17] Nonmedical district school board personnel may not perform sterile catheterization, nasogastric tube feeding, or cleaning and maintaining a tracheostomy or deep suctioning of a tracheostomy. *See* s. 1006.062(3), F.S.

may perform a specific health-related service is determined by authorized licensed health care personnel.[18]

The Administration of Medication by School Board Personnel

District school board personnel may assist students in the administration of certain medication.[19] School personnel designated to assist in the administration of medication must be trained by authorized licensed healthcare personnel.[20]

For each medication prescribed to a student, the principal must obtain from the parent a written explanation of the necessity for the medication to be provided during the school day, including any occasion when the student is away from school property on official school business, and grant permission to assist the student in the administration of such medication.[21] Each prescribed medication to be administered by district school board personnel must be received, counted, and stored in its original container. When the medication is not in use, it must be stored in its original container in a secure fashion under lock and key in a location designated by the school principal.[22]

School personnel administering medication are exempt from liability for civil damages when acting as an ordinarily reasonable prudent person would have acted under the same or similar circumstances.[23]

Individualized Health Care Plans

The school nurse creates individualized health care plans (IHPs) for students with health care needs that, if not addressed, may negatively affect attendance or academic performance. The IHPs foster communication among nursing staff to promote continuity of care.

Depending on the health condition, the IHP may prompt the nurse to develop an emergency care plan (ECP).[24] The ECP is a clearly written step-by-step set of instructions for what to do in a particular emergency situation.[25] Unlike the IHP, the ECP is distributed to appropriate staff, and the school nurse trains that staff to respond to emergencies that may arise with individual students.[26]

[18] Section 1006.062(5), F.S.
[19] Section 1006.062, F.S.
[20] Section 1006.062(1)(a), F.S.
[21] Section 1006.062(1)(b), F.S.
[22] Section 1006.062(1)(b)2., F.S.
[23] Section 1006.062(2), F.S.
[24] *Id*.
[25] Department of Education, *Legislative Bill Analysis for SB 340* (2022). An analysis by DOE of SB 186 or its House companion (HB 1201) has not been received by Senate committee staff as of this writing.
[26] Rule 64F-6.004(4), F.A.C.

Care of Students With Epilepsy or Seizure Disorders

In 2022, the Legislature created s. 1006.0626, F.S., entitled "Care of students with epilepsy or seizure disorders."[27] That section of statute specifies responsibilities for public schools to provide for the care of students with epilepsy or seizure disorders by requiring such schools to initiate the implementation of an individualized seizure action plan (ISAP) once a parent submits an ISAP to the school principal and school nurse, or other appropriate school employee, to inform school personnel of the unique health care services required by the student and how to respond in emergency situations.

Under the 2022 law, s. 1006.0626, F.S., provides that:
- An ISAP means a document that outlines a set of procedural guidelines and specific directions for the provision of health care and emergency services by a school for a student who has epilepsy or seizure disorders.
- "Medical professional" means a physician or physician assistant licensed under chs. 458 or 459, F.S., or an advanced practice registered nurse licensed under s. 464.012, F.S., who provides epilepsy or seizure disorder care to the student in question.
- "School" has the same meaning as in s. 1003.01(17), F.S., which provides that "school" means an organization of students for instructional purposes on an elementary, middle or junior high school, secondary or high school, or other public school level authorized under rules of the State Board of Education.

An ISAP must be developed and signed by a medical professional, in consultation with the student's parent, and must include:
- Written orders from the student's medical professional outlining the student's epilepsy or seizure disorder recommended care.
- The parent's signature.
- The student's epilepsy or seizure disorder symptoms.
- Any accommodations the student requires for school trips, after-school programs and activities, class parties, and any other school-related activities.
- When and whom to call for medical assistance.
- The student's ability to manage, and the student's level of understanding of, his or her epilepsy or seizure disorder.
- How to maintain communication with the student; the student's parent; and the student's health care team, school nurse, and educational staff.
- Any rescue medication prescribed by the student's medical professional and how and when to administer the medication.

The school nurse or an appropriate school employee of a school that receives an ISAP from a student's parent must:
- Coordinate the provision of epilepsy and seizure disorder care at the school for the student, including administering anti-seizure and rescue medications as outlined in the ISAP.
- Verify that each school employee whose duties include regular contact with the student has completed training in the care of students with epilepsy and seizure disorders. The training

[27] Chapter 2022-19, Laws of Florida.

must include how to recognize the symptoms of and provide care for epilepsy and seizure disorders.

To assist schools in meeting this training requirement, the DOE must identify on its website one or more online training courses that are provided by a nonprofit national organization that supports the welfare of individuals with epilepsy and seizure disorders and are available free of charge to schools.

A school that receives an ISAP from a student's parent must provide each school employee whose duties include regular contact with the student, with all of the following:

- Notice of the student's condition.
- Information from the ISAP on how to provide the recommended care for the student if he or she shows symptoms of the epilepsy or seizure disorder.
- The contact information for the student's parent and emergency contacts.

Department of Health — Care and Assistance of Persons with Epilepsy — Establishment of Programs in Epilepsy Control

Under s. 385.207, F.S., the Legislature finds and intends that epilepsy is recognized as a developmental disability and a handicapping condition. The Legislature further intends that persons with epilepsy are entitled to the protection and benefits available to all persons through the equal and nondiscriminatory application and implementation of statutes, rules, programs, and services.

The DOH is required under that section of statute to institute and maintain an educational program among physicians, hospitals, county health departments, and the public concerning epilepsy, including the dissemination of information and the conducting of educational programs concerning the prevention of epilepsy and methods developed and used for the care and treatment of persons with epilepsy.[28]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 385.207, F.S., to require that the DOH's existing educational program among physicians, hospitals, county health departments, and the public concerning epilepsy, must include the education and training requirements of s. 1006.0626(3) and (5), F.S., as amended or created under Section 2 of the bill which pertain to public schools and school personnel.

Section 2 amends the definition of "school" within s. 1006.0626, F.S., to specifically include charter schools under s. 1002.33, F.S.[29]

[28] Section 385.207(2)(e), F.S.

[29] Section 1002.33, F.S., provides, among many other provisions for charter schools, that all charter schools in Florida are public schools and are part of the state's program of public education. However, s. 1002.33(16), F.S., provides that charter schools are exempt from all statutes in chs. 1000-1013, F.S., with a number of exceptions. One exception provides that charter schools must be in compliance with statutes in that range which specifically apply to charter schools. Under current law, s. 1006.0626, F.S., does not specifically apply to charter schools. SB 186, if enacted, will remedy that.

The bill provides that written orders from a student's medical professional for seizure-related services to be provided to the student by a school, as part of the student's ISAP, may be in a form determined by the medical professional.

The bill amends the duties of a school nurse or an appropriate school employee of a school that receives an ISAP from a student's parent. Under the bill, the school nurse or other appropriate school employee must verify the completion of training for the care of students with epilepsy and seizure disorders by school *district* employees (as opposed to "school employees" as under current law) if the duties of such district employees include regular contact with a student who has an ISAP. The bill provides that such employees include those who teach students or transport students to and from school or school activities. The bill provides that the completion of such training is valid for five years.

The bill requires all public schools to display a poster developed by the DOE which describes the basic steps of responding to an individual having a seizure. The DOE must identify one or more posters that are provided by a national nonprofit organization that supports the welfare of individuals with epilepsy and seizure disorders and are available free of charge to schools.

Section 3 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:

The DOH reports that it does not expect SB 186 to have a fiscal or operational impact on the department's educational program among physicians, hospitals, county health departments, and the public concerning epilepsy.[30] As of this writing, however, the DOE has not provided an estimate of the bill's fiscal or operational impacts on the public school system or the department.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The effects of Section 1 of the bill are unclear regarding the DOH's existing educational program for physicians, hospitals, county health departments, and the public concerning epilepsy. The bill requires that the DOH program must include "the education and training requirements" of s. 1006.0626(3) and (5), F.S., as amended or created by the bill which pertain to public schools and school personnel.

- Since the requirements of s. 1006.0626(3) and (5), F.S., pertain to public schools and school personnel, it is unclear from the bill's language whether the bill intends for the DOH to begin providing such education and training to school district employees who are required to complete epilepsy-related education and training under subsection (3) of that statute. The bill does not alter the DOE's existing responsibility to assist schools in meeting the training requirement by identifying one or more online training courses that are available free of charge to schools.
- It is also unclear exactly how the bill intends for the DOH to include in its existing educational program the new requirement for schools to display posters under subsection (5) of that statute, as created by the bill, especially since the bill directs the DOE to identify one or more posters that are provided by a national nonprofit organization that supports the welfare of individuals with epilepsy and seizure disorders and are available free of charge to schools.

Section 2 of the bill requires, among other provisions, that a school nurse or other appropriate school employee must verify that each school *district* employee whose duties include regular contact with a student of that school whose parent has submitted an ISAP, has completed training in the care of students with epilepsy and seizure disorders (as opposed to *school employees* as under current law). The bill provides that such employees include those who teach such students or transport them to and from school or school activities.

[30] Department of Health, *2026 Agency Legislative Bill Analysis: SB 186,* Oct. 15, 2025 (on file with staff of the Senate Committee on Health Policy).

- It is unclear whether the bill intends these requirements to apply to *all* school district employees who meet the criteria or only to such employees of the district who teach or transport such students.
- It is also unclear to what extent a school nurse or other appropriate employee of any particular school will have knowledge of, or authority over, the applicable employees on a district-wide basis who may come into regular contact with such student outside of his or her own school setting or school activities.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 385.207 and 1006.0626.

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.

333962

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment

Delete lines 61 - 64
and insert:
(b) Verify that each school district or charter school employee whose duties include regular contact with the student, including any employee who teaches or transports the student to and from school or school activities, has completed training in the care of

By Senator Garcia

36-00590-26 2026186__

A bill to be entitled

An act relating to student health and safety; amending s. 385.207, F.S.; revising Department of Health responsibilities for educational programs concerning epilepsy; amending s. 1006.0626, F.S.; revising the definition of the term "school"; revising requirements for a student's individualized seizure action plan; revising the list of which employees must complete training in the care of students with epilepsy and seizure disorders; providing that the training is valid for 5 years; requiring schools to display a specified poster; providing an effective date.

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

Section 1. Paragraph (e) of subsection (2) of section 385.207, Florida Statutes, is amended to read:

385.207 Care and assistance of persons with epilepsy; establishment of programs in epilepsy control.—

(2) The Department of Health shall:

(e) Institute and maintain an educational program among physicians, hospitals, county health departments, and the public concerning epilepsy, including the dissemination of information and the conducting of educational programs concerning the prevention of epilepsy and methods developed and used for the care and treatment of persons with epilepsy. <u>The educational program must include the education and training requirements of s. 1006.0626(3) and (5).</u>

Section 2. Paragraph (c) of subsection (1), paragraph (b)

of subsection (2), and paragraph (b) of subsection (3) of section 1006.0626, Florida Statutes, are amended, and subsection (5) is added to that section, to read:

1006.0626 Care of students with epilepsy or seizure disorders.—

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

(c) "School" has the same meaning as in s. 1003.01(17) and includes charter schools under s. 1002.33.

(2)

(b) An ISAP must be developed and signed by a medical professional, in consultation with the student's parent, and include the following:

1. Written orders from the student's medical professional, in a form determined by the medical professional, outlining the student's epilepsy or seizure disorder recommended care.

2. The parent's signature.

3. The student's epilepsy or seizure disorder symptoms.

4. Any accommodations the student requires for school trips, after-school programs and activities, class parties, and any other school-related activities.

5. When and whom to call for medical assistance.

6. The student's ability to manage, and the student's level of understanding of, his or her epilepsy or seizure disorder.

7. How to maintain communication with the student; the student's parent; and the student's health care team, school nurse, and educational staff.

8. Any rescue medication prescribed by the student's medical professional and how and when to administer the medication.

(3) The school nurse or an appropriate school employee of a school that receives an ISAP pursuant to subsection (2) shall:

(b) Verify that each school district employee whose duties include regular contact with the student, including any employee who teaches students or transports students to and from school or school activities, has completed training in the care of students with epilepsy and seizure disorders. The training must include how to recognize the symptoms of and provide care for epilepsy and seizure disorders. To assist schools in meeting this requirement, the Department of Education shall identify on its website one or more online training courses that are provided by a nonprofit national organization that supports the welfare of individuals with epilepsy and seizure disorders and are available free of charge to schools. The completion of training is valid for 5 years.

(5) Each school as defined in paragraph (1)(c) shall display a poster developed by the department which describes the basic steps of responding to an individual having a seizure. The department shall identify one or more posters that are provided by a national nonprofit organization that supports the welfare of individuals with epilepsy and seizure disorders and are available free of charge to schools.

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

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 902
INTRODUCER:	Senator Garcia
SUBJECT:	Department of Health
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke/Smith	Brown	HP	**Pre-meeting**
2.			AHS	
3.			RC	

I. Summary:

SB 902 amends medical marijuana law in s. 381.986, F.S., to:

- Revise the definition of "Low-THC cannabis" to apply the tetrahydrocannabinol (THC) and cannabidiol (CBD) concentration requirements to the final product, rather than to the flower from which the product was derived, and to lower the required amount of CBD from 10 percent to two percent.
- Clarify that qualified physicians[1] and medical marijuana treatment center (MMTC) medical directors must renew their medical marijuana training course and exam certification biennially rather than tying the timing of such recertification to the time when the physician must renew his or her license.
- Restrict MMTC facilities from being located within 500 feet of a park, child care facility, or a facility that provides early learning services, with certain exceptions.
- Remove obsolete language.

The bill amends health care practitioner statutes to require the Department of Health (DOH) to issue an emergency order suspending the license of any health care practitioner who is arrested for committing, or attempting, soliciting, or conspiring to commit, murder.

The bill deletes statutory provisions relating to mediation and dispute resolution, as well as transitioning to the education system, within the Early Steps program, Florida's early intervention program for infants and toddlers with developmental delays and disabilities. The DOH reports that the deletions will allow greater programmatic flexibility within federal guidelines.[2]

[1] As defined in s. 381.986(1)(n), F.S.

[2] Department of Health, *Senate Bill 902 Legislative Analysis*, Jan. 5, 2026 (on file with the Senate Committee on Health Policy).

The bill makes the University of Florida's Center for Autism and Neurodevelopment's autism micro-credential available to Early Steps early intervention service providers.

The bill also revises the Dental Student Loan Repayment (DSLR) program practice settings and patient populations. The bill removes program eligibility for dentists and dental hygienists practicing in medically underserved areas and instead extends eligibility to those providing services in free clinics, state hospitals, and other public institutions that are designated dental health professional shortage areas.

The bill expands the categories of patients who qualify for care under the DSLR program. In addition to Medicaid-enrolled individuals, practitioners participating in the program may, under the bill, serve individuals who are eligible for, but not enrolled in, Medicaid; uninsured individuals whose family income does not exceed 300 percent of the federal poverty level; and individuals who meet the program eligibility guidelines for clients.

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

II. Present Situation:

The Florida Department of Health (DOH)

The DOH is the state's primary public health agency, responsible for safeguarding the health and well-being of residents and visitors. Established in 1996, the DOH operates under the leadership of the State Surgeon General and encompasses various divisions, including Administration, Emergency Preparedness and Community Support, Disease Control and Health Protection, Community Health Promotion, and Medical Quality Assurance (MQA).[3] The DOH comprises a state health office (central office) in Tallahassee, with statewide responsibilities; Florida's 67 county health departments (CHD); eight Children's Medical Services (CMS) area offices; 12 Medical Quality Assurance (MQA) regional offices; nine Disability Determinations regional offices; and three public health laboratories.[4]

Licensure and Regulation of Health Care Practitioners

The Division of Medical Quality Assurance (MQA), within the DOH, has general regulatory authority over health care practitioners.[5] The MQA works in conjunction with 22 regulatory boards and four councils to license and regulate over 1.5 million health care practitioners.[6] Professions are generally regulated by individual practice acts and by ch. 456, F.S., which

[3] Section 20.43, F.S.
[4] Florida Department of Health, *About Us*, available at https://www.floridahealth.gov/about-us/ (last visited Feb. 9, 2026).
[5] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, genic counselors, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[6] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2024-2025*, https://mqawebteam.com/annualreports/2425/ (last visited Feb. 9, 2026).

provides regulatory and licensure authority for the MQA. The MQA is statutorily responsible for the following boards and professions established within the division:[7]

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;
- Nursing assistants, as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;
- Midwifery, as provided under ch. 467, F.S.;
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.;
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.;
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.;
- Respiratory therapy, as provided under part V of ch. 468, F.S.;
- Dietetics and nutrition practice, as provided under part X of ch. 468, F.S.;
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.;
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.;
- Electrolysis, as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part I of ch. 483, F.S.;
- Medical physicists, as provided under part II of ch. 483, F.S.;
- Genetic Counselors as provided under part III of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, created under ch. 490, F.S.;
- School psychologists, as provided under ch. 490, F.S.;
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.; and
- Emergency medical technicians and paramedics, as provided under part III of ch. 401, F.S.

The DOH and the practitioner boards have different roles in the regulatory system. Boards establish practice standards by rule, pursuant to statutory authority and directives. The DOH receives and investigates complaints about practitioners and prosecutes cases for disciplinary action against practitioners.

[7] Section 456.001(4), F.S.

The DOH, on behalf of the professional boards, investigates complaints against practitioners.[8] Once an investigation is complete, the DOH presents the investigatory findings to the boards. The DOH recommends a course of action to the appropriate board's probable cause panel, which may include:[9]

- Issuing an Emergency Order;
- Having the file reviewed by an expert;
- Issuing a closing order; or
- Filing an administrative complaint.

The boards determine the course of action and any disciplinary action to take against a practitioner under the respective practice act.[10] For professions for which there is no board, the DOH determines the action and discipline to take against a practitioner and issues the final orders.[11] The DOH is responsible for ensuring that licensees comply with the terms and penalties imposed by the boards.[12] If a case is appealed, DOH attorneys defend the final actions of the boards before the appropriate appellate court.[13]

DOH and board rules apply to all statutory grounds for discipline against a practitioner. Under current law, the DOH takes on the disciplinary functions of a board relating to violations of a practice act only for practitioner types that do not have a board. The DOH itself takes no final disciplinary action against practitioners for which there is a board.

In extreme circumstances, pursuant to s. 120.60, F.S., the DOH may issue an emergency order suspending the license of a health care practitioner if necessary to protect the public health, safety, or welfare. If a health care practitioner pleads guilty to, is convicted or found guilty of, enters a plea of nolo contendere to, or is arrested for certain acts or offenses pursuant to s. 456.074, F.S., the DOH is required to immediately suspend the practitioner's license.

Dental Student Loan Repayment Program

Section 381.4019, F.S., creates the Dental Student Loan Repayment (DSLR) program. The program is available to Florida-licensed dentists and dental hygienists who:

- Demonstrate active employment in a public health program or private practice that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or a medically underserved area;[14] and

[8] Department of Health, *Investigative Services,* available at https://www.floridahealth.gov/licensing-regulations/complaints-enforcement/complaint-forms/investigative-services/ (last visited Feb. 9, 2026).
[9] *Id.*
[10] Section 456.072(2), F.S.
[11] Professions which do not have a board include naturopathy, nursing assistants, midwifery, respiratory therapy, dietetics and nutrition, electrolysis, medical physicists, genetic counselors, and school psychologists.
[12] *Supra* note 3.
[13] *Id.*
[14] The section ties the definition of "dental health professional shortage area" to those areas that are designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services and defines "medically underserved area" as a geographic area, an area having a special population, or a facility which is designated by DOH rule as a health professional shortage area as defined by federal regulation and which has a shortage of dental health professionals who serve Medicaid recipients and other low-income patients.

- Volunteer 25 hours per year providing dental services in a free clinic that is located in a dental health professional shortage area or a medically underserved area, through another volunteer program operated by the state pursuant to part IV of ch. 110, F.S., or through a pro bono program approved by the Board of Dentistry.

Under the DSLR program, a dentist or dental hygienist can receive reimbursement for repaying his or her student loans up to the lesser of 20 percent of his or her loan amount or $50,000 per year. A dentists or dental hygienist may receive an award from the program for up to five years, which are not required to be consecutive, so long as the dentist or dental hygienists maintains eligibility.

Medical Marijuana

Low-THC Cannabis

Section 381.986(1)(f), F.S., defines "Low-THC cannabis" to mean plant of the genus *Cannabis*, the dried flowers of which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight; the seeds thereof; the resin extracted from any part of such plant; or any compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or resin that is dispensed from a medical marijuana treatment center.

Each MMTC is required to produce and make available at least one low-THC cannabis product.[15] Prior to the implementation of the DOH's seed-to-sale tracking (seed-to-sale) system in 2024, MMTCs were self-reporting low-THC cannabis dispensations through the Medical Marijuana Use Registry. After implementation, the seed-to-sale system indicated a 67 percent decrease in the number of low-THC cannabis products dispensed during state fiscal year 2024-2025.

Since existing regulations only require products to be tested after processing, the determination of whether a product meets the definition of low-THC cannabis is tied to the potency of the final product rather than to the potency of the low-THC whole flower. The seed-to-sale system currently captures the THC-to-CBD ratio of each final product as reported on the Certificate of Analysis. The system will not recognize a dispensation as "low-THC cannabis" unless the final product being dispensed meets the current statutory definition. The current definition, which ties the concentrations of THC and CBD to the dried flower before processing, presents enforcement challenges for the DOH Office of Medical Marijuana Use (OMMU).[16]

MMTC Locations

Section 381.986(11), F.S., prohibits MMTC cultivation, processing, and dispensing facilities from being located within 500 feet of a public or private elementary school, middle school, or secondary school. However, s. 381.986(11)(c), F.S., permits a county or municipality to approve a dispensing facility that is located within 500 feet of a public or private elementary school, middle school, or secondary school through a formal proceeding that is open to the public where that county or municipality determines that the location promotes the public health, safety, and

[15] Section 381.986(8)(e)7., F.S.
[16] Department of Health, *supra* note 2.

general welfare of the community. Additionally, a county or municipality may, by ordinance, ban MMTC dispensing facilities from being located within the boundaries of that county or municipality. A county or municipality that does not ban dispensing facilities may not place specific limits, by ordinance, on the number of dispensing facilities that may locate within that county or municipality. Existing law does not impose site restrictions on MMTC facilities operating near a park, childcare facility, or early learning facility. Approximately 193 MMTC facilities are currently operating within 500 feet of such locations.[17]

Federal Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA)[18] is the main federal statute governing special education and early intervention services for children with disabilities from birth through age 21. The IDEA makes available a free, appropriate public education (FAPE) to eligible children with disabilities and ensures special education and related services to those children. The IDEA governs how states and public agencies provide early intervention, special education, and related services to more than eight million (as of school year 2022-23) eligible infants, toddlers, children, and youth with disabilities.[19]

The Grants for Infants and Families Program (Part C of IDEA)

The Grants for Infants and Families program, also known as part C of the IDEA, awards grants to assist states in implementing statewide systems of coordinated, comprehensive, multidisciplinary, interagency programs and making early intervention services (EIS) available to children with disabilities, aged birth through two, and their families,[20] usually as provided pursuant to an individualized family support or service plan (IFSP).

EIS provides for the early identification and treatment of recipients under the age of three years (36 months), who are at-risk[21] of having, or who have, developmental delays or related conditions.[22] The IDEA requires that EIS be provided, to the maximum extent appropriate, in natural environments. These services can be provided in another setting only when EIS cannot be achieved satisfactorily for the infant or toddler in a natural environment. The natural environment includes the home and community settings where children would be participating if they did not have a disability.[23]

An IFSP is a document or written plan that contains information on the child's present level of development in all areas, outcomes for the child and family, and services the child and family will receive to help them achieve the outcomes.

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[17] *Id.*
[18] The Education for All Handicapped Children Act became law in 1975 and was reauthorized as the Individuals with Disabilities Education Act.
[19] Individuals with Disabilities Education Act, *About IDEA, History of the IDEA, available at* https://sites.ed.gov/idea/about-idea/#IDEA-History (last visited Feb. 6, 2026).
[20] U.S. Department of Education, *Early Intervention Program for Infants and Toddlers with Disabilities, Purpose, available at* https://www2.ed.gov/programs/osepeip/index.html (last visited Feb. 9, 2026).
[21] 34 C.F.R. s. 303.5.
[22] Agency for Health Care Administration, *Florida Medicaid Early Intervention Services Coverage Policy, available at* https://ahca.myflorida.com/content/download/5946/file/59G-4.085_EIS_Coverage_Policy_9.22.2023.pdf (last visited Feb. 9, 2026).
[23] U.S. Department of Education, s*upra* note 20.

State agencies identified as the lead agency for the part C program may apply for grant funds.[24] Funds allocated under part C can be used to:[25]

- Maintain and implement a state's EIS system;
- Fund direct EIS for infants and toddlers with disabilities and their families that are not otherwise provided by other public or private sources;
- Expand and improve services that are otherwise available;
- Provide a FAPE to children with disabilities from their third birthday to the beginning of the following school year;
- Continue to provide EIS to children with disabilities from their third birthday until such children enter or are eligible to enter kindergarten or elementary school; and
- Initiate, expand, or improve collaborative efforts related to identifying, evaluating, referring, and following up on at-risk infants and toddlers in states that do not provide direct services for these children.

Part C Extended Option

The IDEA gives states the discretion to provide an option for eligible children with disabilities to continue to receive part C services after the child ages-out or turns three years old. The child must be enrolled in part C and deemed eligible for services under part B of the IDEA. The state has the flexibility to extend part C services until the child enters or is eligible under state law to enter kindergarten or elementary school, as appropriate.[26]

Florida's Early Steps Program and Part C Implementation

Florida's Early Steps Program,[27] administered by the DOH,[28] under the Division of Children's Medical Services (CMS),[29] provides free,[30] individual and group therapies and services needed to enhance the growth and development and family functioning of infants and toddlers from birth until three years of age who have or are at risk of developmental delays or disabilities. For purposes of the Early Steps Program, the state of Florida defines "developmental disability" to mean a condition, identified and measured through appropriate instruments and procedures, which may impair physical, cognitive, communication, social or emotional, or adaptive development.[31]

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[24] Individuals with Disabilities Education Act, *Section 1437, available at* https://sites.ed.gov/idea/statute-chapter-33/subchapter-iii/1437 (last visited Feb. 9, 2026).
[25] U.S. Department of Education, s*upra* note 20.
[26] *Id.*
[27] Section 391.308, F.S.
[28] Section 381.001, F.S.
[29] Department of Health, *Division of Children's Medical Services, available at* https://www.floridahealth.gov/individual-family-health/child-infant-youth/special-health-care-needs/cms/ (last visited Feb. 9, 2026).
[30] Department of Health, Early Steps, *Milestone Development Guide, available at* https://floridaearlysteps.com/wp-content/uploads/2022/04/ES_MilestoneDevelopmentGuide_English_sm.pdf (last visited Feb. 9, 2026).
[31] Section 391.302, F.S.

Children can be referred to the Early Steps Program in various ways. Referrals can be submitted by anyone involved in the care of the child, including parents, caregivers, and physicians. To be enrolled in the Early Steps Program, a child must first be found eligible.[32]

Children with an established condition that places them at-risk of developmental delay, as well as children with certain documented physical or mental at-risk conditions, may be eligible for services through the Early Steps Program.[33]

If a child has no diagnosed condition but there are concerns about potential developmental delay, a team of early intervention professionals will collaborate to screen, evaluate, and assess the child in the following areas:[34]

- Physical: health, hearing, vision;
- Cognitive: thinking, learning, problem-solving;
- Gross and Fine Motor Skills: moving, walking, grasping, coordination;
- Communication: babbling, languages, speech, conversation;
- Social and Emotional: playing and interacting with others; and
- Adaptive Development: self-help skills (feeding, toileting, dressing).

If a child is determined eligible, Early Steps Program staff will put together a team to address the child's needs and develop an IFSP. The IFSP team includes the family, a service coordinator, and at least two professionals from two different disciplines that have been or are currently involved in the assessment and provision of the child's services. Specialists are also available to address the child's individualized needs.[35]

The Early Steps Program provides the following services, working closely with families to understand their child's needs to help them succeed:[36]

- Developmental monitoring, screening, and evaluation;
- Professional support and service coordination;
- Individualized early intervention sessions;
- Occupational, physical, and speech therapies;
- Hearing and vision services; and
- Assistive technology.

In 2025, the Legislature enacted CS/CS/SB 112, an act relating to Children with Developmental Disabilities, which took effect upon becoming a law on May 27, 2025.[37] The bill requires the DOH to submit an application for federal approval to extend eligibility for services and implementing the Early Steps Extended Option under part C of the IDEA no later than July 1, 2026. The Early Steps Extended Option would allow eligible children to continue receiving services through the Early Steps Program until the beginning of the school year following their

[32] Florida Early Steps, *Eligibility and Screening, available at* https://floridaearlysteps.com/eligibility-and-screening/ (last visited Feb. 9, 2026).
[33] *Id*.
[34] *Id*.
[35] *Id*.
[36] Florida Early Steps, *About Early Steps, available at* https://floridaearlysteps.com/about/ (last visited Feb. 9, 2026).
[37] Chapter 2025-95, Laws of Fla.

fourth birthday, contingent on obtaining legislative funding, but not contingent on receiving federal funding.

Autism Micro-Credential[38]

The University of Florida Center for Autism and Neurodevelopment provides a micro-credential to provide specialized training in supporting students with autism. The micro-credential is currently available to instructional personnel, prekindergarten instructors, and child care professionals.as defined in s. 1012.01(2), F.S. This training equips instructional and child care personnel with skills in identifying autism-related behaviors, supporting the classroom environment, using assistive technologies, and applying evidence-based practices.

Currently, Early Steps Program service providers are not eligible to receive this micro-credential. With the passage of CS/CS/SB 112 in 2025, Early Steps Program providers must include an educational component for children choosing to remain in Early Steps for the Extended Option to the Individualized Family Support Plan (IFSP), and this micro-credential provides personnel with training related to that new educational component requirement.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 381.4019, F.S., to revise the DSLR program's definitions and eligibility criteria by:

- Revising the definition of "dental health professional shortage area" to include HRSA-designated areas with a special population and facilities.
- Deleting the statutory definition and mentions of "medically underserved area."

In effect, this would enable dentists and dental hygienists who work in any type of HRSA-designated dental health professional shortage areas to participate in the program and would exclude dentists and dental hygienists who work in HRSA-designated medically underserved areas from participation.

The bill also revises eligibility criteria by:

- Defining "low-income" by cross-reference to s. 766.1115(3)(e), F.S.[39]
- Requiring dentists and dental hygienists participating in the program to serve low-income patients.
- Removing the requirement that dentists and dental hygienists participating in the program serve Medicaid recipients.

The bill also revises the volunteer service requirement by deleting language requiring that certain volunteer hours occur in a program "operated by the state," thereby expanding the types of qualifying volunteer opportunities available to award recipients (while retaining the requirement that hours be verifiable as determined by the DOH).

[38] Department of Health, *supra* note 2.

[39] "Low-income" under s. 766.1115(3)(e), F.S., means: A person who is Medicaid-eligible under Florida law; a person who is without health insurance and whose family income does not exceed 300 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or any client of the DOH who voluntarily chooses to participate in a program offered or approved by the DOH and meets the program eligibility guidelines of the department.

Section 2 of the bill amends s. 381.986, F.S., to:

- Apply the THC and CBD concentration requirements for low-THC cannabis to the final product, rather than to the flower from which the product was derived.
- Lower the required concentration of CBD to meet the definition of low-THC cannabis from 10 percent to two percent.
- Require qualified physicians and MMTC medical directors to renew their medical marijuana training course and exam certification biennially rather than "before each licensure renewal" in order to provide flexibility for when the physician takes the course rather than tying it to his or her licensure renewal.
- Restrict MMTC facilities from being located within 500 feet of a park, child care facility, or a facility that provides early learning services. The bill exempts facilities that were approved prior to July 1, 2026, from the new restriction and also specifies that any park, child care facility, early learning facility, or school that is established after the approval of the MMTC facility does not affect its continued operation.
- Remove obsolete references to former s. 381.986, F.S., (2016) and the compassionate use registry.

Sections 3 of the bill amends s. 391.308, F.S., to delete Florida-specific language directing the DOH to provide mediation and, if necessary, an appeals process for applicants found ineligible for developmental evaluation or early intervention services, or denied financial support. The bill instead, requires the DOH to establish procedures for dispute resolution and mediation as outlined in part C of the IDEA.

Sections 3 and 4 of the bill amend ss. 391.308 and 391.3081, F.S., respectively, to replace detailed, locally-executed transition directives with a requirement that the DOH "establish statewide uniform protocols and procedures" for transition to a school district program or another program as part of the IFSP pursuant to IDEA part C. In doing so, the bill deletes statutory requirement that at least 90 days before the child turns three years old, or four years old for a child in the Extended Option, the local program office must notify the local school district and the Department of Education (subject to opt-out) and, with parental approval, convene a transition conference with school district participation.

Section 5 of the bill amends s. 456.074(5), F.S., to require the DOH to issue an emergency order suspending the license of a health care practitioner upon arrest[40] for committing (or attempting, soliciting, or conspiring to commit) murder (s. 782.04, F.S.) in this state or a similar offense in another jurisdiction.

Section 6 of the bill amends s. 1004.551, F.S., to add Early Steps-credentialed early intervention service providers to the list of individuals eligible for the University of Florida Center for Autism and Neurodevelopment's autism micro-credential.

[40] A warrantless arrest is reasonable when the officer has probable cause to believe the suspect committed a crime in the officer's presence. *Atwater v. City of Lago Vista*, 532 U.S. 318, 354 (2001). Probable cause "requires only a probability or substantial chance of criminal activity, not an actual showing of such activity." *Illinois v. Gates*, 462 U.S. 213, 243–44 n.13 (1983). In other words, probable cause "is not a high bar." *Kaley v. United States*, 571 U.S. 320, 338 (2014).

Section 7 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:

The bill provides that a health care practitioner who is arrested[41] for murder will have his or her license suspended. Florida Constitution (Art. I, § 9) provides that "[n]o person shall be deprived of life, liberty or property without due process of law," which means the state must use fair procedures before taking away a protected interest such as a professional license. Likewise, the U.S. Constitution's Fourteenth Amendment bars any state from depriving a person of "life, liberty, or property, without due process of law." If there's an immediate danger, due process usually allows the state to act first (e.g., an emergency/summary suspension) without a full pre-suspension hearing, as long as the procedure is "fair under the circumstances" and the licensee gets a prompt post-deprivation opportunity to challenge it.

> "… an emergency order issued prior to a hearing must set forth facts sufficient to demonstrate immediate danger, necessity, and procedural fairness.. Fairness requires that the order provide a remedy that is tailored to address the harm and provide for an administrative hearing. Section 120.60(6)(c) requires, in cases of summary suspension, that the Department promptly institute a formal suspension or revocation proceeding...42

The DOH must ensure that each licensee whose license is suspended through an emergency order promptly receives a formal proceeding at which the health care practitioner can dispute the factual matters in the arrest that were relied on by the DOH.

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[41] *Id*.

[42] *Field v. State, Dep't of Health*, 902 So. 2d 893, 895 (Fla. Dist. Ct. App. 2005). *See Witmer v. Dep't of Bus. and Prof'l Regulation,* 631 So.2d 338 (Fla. 4th DCA 1994) *See Daube v. Dep't of Health,* 897 So.2d 493 (Fla. 1st DCA 2005); *Premier Travel Int'l, Inc. v. Dep't of Agric.,* 849 So.2d 1132, 1137 (Fla. 1st DCA 2003); *White Constr. Co., Inc. v. State, Dep't of Transp.,* 651 So.2d 1302, 1305 (Fla. 1st DCA 1995).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None identified.

B. Private Sector Impact:

Any impact that this bill may have on the private sector is indeterminate.

C. Government Sector Impact:

The DOH expects this bill to have no fiscal impact. The DOH notes that the bill would have a minimal, nonrecurring workload and technology impact related to updating enforcement and case codes within MQA systems, which is expected to be absorbed within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.4019, 381.986, 391.308, 391.3081, 456.074, and 1004.551.

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.

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LEGISLATIVE ACTION

Senate . House

. . . . . .

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

Senate Amendment (with title amendment)

Delete lines 49 - 93.

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

And the title is amended as follows:

Delete lines 3 - 9

and insert:

s. 381.986, F.S.; revising

674674

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Between lines 345 and 346
insert:

Section 6. Paragraph (c) of subsection (2) of section 464.0156, Florida Statutes, is amended to read:

464.0156 Delegation of duties.—

(2)

(c) A registered nurse may not delegate the administration of any controlled substance listed in Schedule II, Schedule III,

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or Schedule IV of s. 893.03 or 21 U.S.C. s. 812, except that a registered nurse may delegate:

1. ~~For~~ The administration of an insulin syringe that is prefilled with the proper dosage by a pharmacist or an insulin pen that is prefilled by the manufacturer; and

2. To a home health aide for medically fragile children as defined in s. 400.462 the administration of a Schedule IV controlled substance prescribed for the emergency treatment of an active seizure.

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

And the title is amended as follows:

Between lines 41 and 42

insert:

464.0156, F.S.; authorizing a registered nurse to delegate the administration of certain controlled substances to a home health aide for medically fragile children under certain circumstances; amending s.

By Senator Garcia

36-00592C-26 2026902__

A bill to be entitled

An act relating to the Department of Health; amending s. 381.4019, F.S.; revising the definition of the term "dental health professional shortage area"; defining the term "low-income"; deleting the definition of the term "medically underserved area"; revising eligibility requirements for dentists and dental hygienists participating in the Dental Student Loan Repayment Program; amending s. 381.986, F.S.; revising the definition of the term "low-THC cannabis"; revising requirements for department approval of qualified physicians and medical directors of medical marijuana treatment centers; deleting obsolete language; prohibiting medical marijuana treatment center cultivating, processing, or dispensing facilities from being located within a specified distance of parks, child care facilities, or facilities providing early learning services; authorizing counties and municipalities to approve a dispensing facility within such distance under certain circumstances; providing that the subsequent establishment of any park, child care facility, early learning facility, or school after the approval of a medical marijuana treatment center's cultivating, processing, or dispensing facility does not affect the continued operation or location of the approved cultivating, processing, or dispensing facility; exempting cultivating, processing, or dispensing facilities approved before a specified date from such

distance requirements; amending s. 391.308, F.S.; revising duties of the department in administering the Early Steps Program; revising provisions related to transitioning children from the Early Steps Program to school district programs; amending s. 391.3081, F.S.; revising provisions relating to the Early Steps Extended Option to conform to changes made by the act; amending s. 456.074, F.S.; requiring the department to issue an emergency order suspending the license of a health care practitioner arrested for committing or attempting, soliciting, or conspiring to commit murder in this state or another jurisdiction; amending s. 1004.551, F.S.; revising requirements for the micro-credential component of specialized training provided by the University of Florida Center for Autism and Neurodevelopment; providing an effective date.

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

Section 1. Paragraphs (a) and (e) of subsection (1), paragraphs (a) and (b) of subsection (2), and paragraph (b) of subsection (4) of section 381.4019, Florida Statutes, are amended to read:

381.4019 Dental Student Loan Repayment Program.—The Dental Student Loan Repayment Program is established to support the state Medicaid program and promote access to dental care by supporting qualified dentists and dental hygienists who treat medically underserved populations in dental health professional shortage areas or medically underserved areas.

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

(a) "Dental health professional shortage area" means a geographic area, an area with a special population, or a facility designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(e) "Low-income," with respect to a person, means a person who meets the criteria specified in s. 766.1115(3)(e) ~~"Medically underserved area" means a geographic area, an area having a special population, or a facility which is designated by department rule as a health professional shortage area as defined by federal regulation and which has a shortage of dental health professionals who serve Medicaid recipients and other low-income patients~~.

(2) The department shall establish a dental student loan repayment program to benefit Florida-licensed dentists and dental hygienists who:

(a) Demonstrate, as required by department rule, active employment in a public health program or private practice that serves ~~Medicaid recipients and other~~ low-income patients and is located in a dental health professional shortage area ~~or a medically underserved area~~; and

(b) Volunteer 25 hours per year providing dental services in a free clinic that is located in a dental health professional shortage area or ~~a medically underserved area,~~ through another volunteer program operated under ~~by the state pursuant to~~ part IV of chapter 110, or through a pro bono program approved by the Board of Dentistry. In order to meet the requirements of this paragraph, the volunteer hours must be verifiable in a manner

determined by the department.

(4) A dentist or dental hygienist is not eligible to receive funds under the loan program if the dentist or dental hygienist:

(b) Ceases to provide services to low-income patients ~~participate in the Florida Medicaid program~~.

Section 2. Paragraph (f) of subsection (1), paragraphs (a) and (c) of subsection (3), paragraph (h) of subsection (4), paragraph (a) of subsection (8), and paragraphs (a) and (c) of subsection (11) of section 381.986, Florida Statutes, are amended to read:

381.986 Medical use of marijuana.—

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

(f) "Low-THC cannabis" means a plant of the genus *Cannabis*, whether growing or not ~~the dried flowers of which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight~~; the seeds thereof; the resin extracted from any part of such plant; and every ~~or any~~ compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or resin, excluding edibles; which contains 0.8 percent or less of tetrahydrocannabinol and 2 percent cannabidiol, weight for weight, which ~~that~~ is dispensed from a medical marijuana treatment center.

(3) QUALIFIED PHYSICIANS AND MEDICAL DIRECTORS.—

(a) Before being approved as a qualified physician ~~and before each license renewal~~, a physician must successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which encompass the requirements of this

section and any rules adopted hereunder. Qualified physicians must renew the course certification biennially. The course and examination must be administered at least annually and may be offered in a distance learning format, including an electronic, online format that is available upon request. The price of the course may not exceed $500.

(c) Before being employed as a medical director ~~and before each license renewal~~, a medical director must successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which encompass the requirements of this section and any rules adopted hereunder. Medical directors must renew the course certification biennially. The course and examination must be administered at least annually and may be offered in a distance learning format, including an electronic, online format that is available upon request. The price of the course may not exceed $500.

(4) PHYSICIAN CERTIFICATION.—

~~(h) An active order for low-THC cannabis or medical cannabis issued pursuant to former s. 381.986, Florida Statutes 2016, and registered with the compassionate use registry before June 23, 2017, is deemed a physician certification, and all patients possessing such orders are deemed qualified patients until the department begins issuing medical marijuana use registry identification cards.~~

(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(a) The department shall license medical marijuana treatment centers to ensure reasonable statewide accessibility and availability as necessary for qualified patients registered

in the medical marijuana use registry and who are issued a physician certification under this section.

1. As soon as practicable, but no later than July 3, 2017, the department shall license as a medical marijuana treatment center any entity that holds an active, unrestricted license to cultivate, process, transport, and dispense low-THC cannabis, medical cannabis, and cannabis delivery devices, under former s. 381.986, Florida Statutes 2016, before July 1, 2017, and which meets the requirements of this section. In addition to the authority granted under this section, these entities are authorized to dispense low-THC cannabis, medical cannabis, and cannabis delivery devices ordered pursuant to former s. 381.986, Florida Statutes 2016, ~~which were entered into the compassionate use registry before July 1, 2017,~~ and are authorized to begin dispensing marijuana under this section on July 3, 2017. The department may grant variances from the representations made in such an entity's original application for approval under former s. 381.986, Florida Statutes 2014, pursuant to paragraph (e).

2. The department shall license as medical marijuana treatment centers 10 applicants that meet the requirements of this section, under the following parameters:

a. As soon as practicable, but no later than August 1, 2017, the department shall license any applicant whose application was reviewed, evaluated, and scored by the department and which was denied a dispensing organization license by the department under former s. 381.986, Florida Statutes 2014; which had one or more administrative or judicial challenges pending as of January 1, 2017, or had a final ranking within one point of the highest final ranking in its region

under former s. 381.986, Florida Statutes 2014; which meets the requirements of this section; and which provides documentation to the department that it has the existing infrastructure and technical and technological ability to begin cultivating marijuana within 30 days after registration as a medical marijuana treatment center.

b. As soon as practicable, the department shall license one applicant that is a recognized class member of *Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999), or *In Re Black Farmers Litig.*, 856 F. Supp. 2d 1 (D.D.C. 2011). An applicant licensed under this sub-subparagraph is exempt from the requirement of subparagraph (b)2. An applicant that applies for licensure under this sub-subparagraph, pays its initial application fee, is determined by the department through the application process to qualify as a recognized class member, and is not awarded a license under this sub-subparagraph may transfer its initial application fee to one subsequent opportunity to apply for licensure under subparagraph 4.

c. As soon as practicable, but no later than October 3, 2017, the department shall license applicants that meet the requirements of this section in sufficient numbers to result in 10 total licenses issued under this subparagraph, while accounting for the number of licenses issued under sub-subparagraphs a. and b.

3. For up to two of the licenses issued under subparagraph 2., the department shall give preference to applicants that demonstrate in their applications that they own one or more facilities that are, or were, used for the canning, concentrating, or otherwise processing of citrus fruit or citrus

molasses and will use or convert the facility or facilities for the processing of marijuana.

4. Within 6 months after the registration of 100,000 active qualified patients in the medical marijuana use registry, the department shall license four additional medical marijuana treatment centers that meet the requirements of this section. Thereafter, the department shall license four medical marijuana treatment centers within 6 months after the registration of each additional 100,000 active qualified patients in the medical marijuana use registry that meet the requirements of this section.

(11) PREEMPTION.—Regulation of cultivation, processing, and delivery of marijuana by medical marijuana treatment centers is preempted to the state except as provided in this subsection.

(a) A medical marijuana treatment center cultivating or processing facility may not be located within 500 feet of the real property that comprises a park as defined in s. 775.215(1), a child care facility as defined in s. 402.302, a facility that provides early learning services as specified in s. 1000.04(1), or a public or private elementary school, middle school, or secondary school. The subsequent establishment of any such park, child care facility, early learning facility, or school after the approval of the medical marijuana treatment center cultivating or processing facility does not affect the continued operation or location of the approved cultivating or processing facility. A medical marijuana treatment center cultivating or processing facility that was approved by the department before July 1, 2026, is exempt from the distance restrictions from a park, child care facility, or early learning facility.

(c) A medical marijuana treatment center dispensing facility may not be located within 500 feet of the real property that comprises a park as defined in s. 775.215(1), a child care facility as defined in s. 402.302, a facility that provides early learning services as specified in s. 1000.04(1), or a public or private elementary school, middle school, or secondary school unless the county or municipality approves the location through a formal proceeding open to the public at which the county or municipality determines that the location promotes the public health, safety, and general welfare of the community. The subsequent establishment of any such park, child care facility, early learning facility, or school after the approval of the medical marijuana treatment center dispensing facility does not affect the continued operation or location of the approved dispensing facility. A medical marijuana treatment center dispensing facility that was approved by the department before July 1, 2026, is exempt from the distance restrictions from a park, child care facility, or early learning facility.

Section 3. Paragraphs (a) and (j) of subsection (2) and paragraphs (a) and (b) of subsection (7) of section 391.308, Florida Statutes, are amended to read:

391.308 Early Steps Program.—The department shall implement and administer part C of the federal Individuals with Disabilities Education Act (IDEA), which shall be known as the "Early Steps Program."

(2) DUTIES OF THE DEPARTMENT.—The department shall:

(a) Annually prepare a grant application to the Federal Government requesting ~~the United States Department of Education for~~ funding for early intervention services for infants and

toddlers with disabilities and their families pursuant to part C of the federal Individuals with Disabilities Education Act.

(j) Establish procedures for dispute resolution and mediation as outlined in part C of the federal Individuals with Disabilities Education Act ~~Provide a mediation process and if necessary, an appeals process for applicants found ineligible for developmental evaluation or early intervention services or denied financial support for such services~~.

(7) TRANSITION TO EDUCATION.—

(a) The department shall establish statewide uniform protocols and procedures for transition to a school district program for children with disabilities or to another program as part of an individual family support plan pursuant to part C of the federal Individuals with Disabilities Education Act ~~At least 90 days before a child reaches 3 years of age, the local program office shall initiate transition planning to ensure the child's successful transition from the Early Steps Program to a school district program for children with disabilities or to another program as part of an individual family support plan.~~

~~(b) At least 90 days before a child reaches 3 years of age, the local program office shall:~~

~~1. Notify the local school district in which the child resides and the Department of Education that the child may be eligible for special education or related services as determined by the local school district pursuant to ss. 1003.21 and 1003.57, unless the child's parent or legal guardian has opted out of such notification; and~~

~~2. Upon approval by the child's parent or legal guardian, convene a transition conference that includes participation of a~~

~~local school district representative and the parent or legal guardian to discuss options for and availability of services~~.

Section 4. Subsection (5) of section 391.3081, Florida Statutes, is amended to read:

391.3081 Early Steps Extended Option.—

(5) TRANSITION TO EDUCATION.—The department shall establish statewide uniform protocols and procedures for transition to a school district program for children with disabilities or to another program as part of an individual family support plan pursuant to part C of the federal Individuals with Disabilities Education Act.

~~(a) At least 90 days before the beginning of the school year following the fourth birthday of a child enrolled in the Early Steps Extended Option, the local program office shall initiate transition planning to ensure the child's successful transition from the Early Steps Extended Option to a school district program under part B of the federal Individuals with Disabilities Education Act or to another program as part of an individual family support plan. Specifically, the local program office shall:~~

~~1. Notify the Department of Education and the local school district in which the child resides that the eligible child is exiting the Early Steps Extended Option, unless the child's parent or legal guardian has opted out of such notification; and~~

~~2. Upon approval by the child's parent or legal guardian, convene a transition conference that includes participation of a local school district representative and the parent or legal guardian to discuss options for and availability of services.~~

~~(b) The local program office, in conjunction with the local~~

~~school district, shall modify a child's individual family support plan, or, if applicable, the local school district shall develop or review an individual education plan for the child pursuant to ss. 1003.57, 1003.571, and 1003.5715 which identifies special education or related services that the child will receive and the providers or agencies that will provide such services.~~

~~(c) If a child is found to be no longer eligible for part B of the federal Individuals with Disabilities Education Act during the review of an individual education plan, the local program office and the local school district must provide the child's parent or legal guardian with written information on other available services or community resources.~~

Section 5. Present paragraphs (d) through (hh) of subsection (5) of section 456.074, Florida Statutes, are redesignated as paragraphs (e) through (ii), respectively, and a new paragraph (d) is added to that subsection, to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(5) The department shall issue an emergency order suspending the license of any health care practitioner who is arrested for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of any of the following criminal offenses in this state or similar offenses in another jurisdiction:

(d) Section 782.04, relating to murder.

Section 6. Paragraph (f) of subsection (1) of section 1004.551, Florida Statutes, is amended to read:

1004.551 University of Florida Center for Autism and

Neurodevelopment.—There is created at the University of Florida the Center for Autism and Neurodevelopment.

(1) The center shall:

(f) Develop an autism micro-credential to provide specialized training in supporting students with autism.

1. The micro-credential must be stackable with the autism endorsement and be available to:

a. Instructional personnel as defined in s. 1012.01(2);

b. Prekindergarten instructors as specified in ss. 1002.55, 1002.61, and 1002.63; and

c. Child care personnel as defined in ss. 402.302(3) and 1002.88(1)(e).

d. Early intervention service providers credentialed through the Early Steps Program.

2. The micro-credential must require participants to demonstrate competency in:

a. Identifying behaviors associated with autism.

b. Supporting the learning environment in both general and specialized classroom settings.

c. Promoting the use of assistive technologies.

d. Applying evidence-based instructional practices.

3. The micro-credential must:

a. Be provided at no cost to eligible participants.

b. Be competency-based, allowing participants to complete the credentialing process either in person or online.

c. Permit participants to receive the micro-credential at any time during training once competency is demonstrated.

4. Individuals eligible under subparagraph 1. who complete the micro-credential are eligible for a one-time stipend, as

determined in the General Appropriations Act. The center shall administer stipends for the micro-credential.

Section 7. This act shall take effect July 1, 2026.

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 196
INTRODUCER:	Senator Sharief and others
SUBJECT:	Uterine Fibroid Research Database
DATE:	February 10, 2026 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 196 removes the prohibition against including personal identifying information in the uterine fibroid research database because, under current law, the Department of Health (DOH) is unable to effectively implement the legislative purpose of the uterine fibroid research database without this information being submitted to the database.

The bill also requires the DOH to add uterine fibroids to the list of reportable diseases maintained under s. 381.0031(4), F.S., which requires health care providers and facilities to report certain diseases to the DOH. The bill specifies that information collected under this requirement is subject to s. 381.0031, F.S.

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. 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

[1] Department of Health, *Diseases & Conditions: Uterine Fibroids*, *available at* http://floridahealth.gov/diseases-and-conditions/disease/uterine-fibroids/ (last visited Feb. 2, 2026).

progesterone play a role. Many women never have symptoms, but some do. Symptoms include abnormal bleeding, pelvic discomfort, pelvic pain, bladder problems, and bowel problems.

Fibroids may be treated depending on the impact they have on the affected 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

In 2022, the Legislature created s. 381.9312, F.S., requiring 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 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]

DOH Mandated Reporting Requirements for Health Care Practitioners

All practitioners, health care facilities, and laboratories in Florida are required to notify the DOH of diseases or conditions of public health significance.[10] DOH rules require reporting for each

[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).
[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] Section 381.0031, F.S.

disease for which the DOH seeks to immunize children under its Immunization Guidelines. For those specified diseases, practitioners must report as follows:

- Immediately upon initial suspicion, or upon ordering a test: measles; rubella; diphtheria; *Haemophilus influenzae* type b (Hib); polio; and pneumococcal disease caused by *Streptococcus pneumoniae*.
- Immediately upon confirmatory test or diagnosis: pertussis (whooping cough).
- By the next business day: hepatitis B (Hep B); mumps; tetanus; and varicella (chickenpox).[11]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 381.9312, F.S., which currently establishes the uterine fibroid research database, to delete a prohibition on the inclusion of any personal identifying information of women diagnosed with or treated for uterine fibroids in the database.

The bill requires the DOH to include uterine fibroids in the list of diseases issued under s. 381.0031(4), F.S. That section requires the DOH to maintain a list of infectious or noninfectious diseases it determines to be a threat to public health. All practitioners, health care facilities, and laboratories in Florida are required to notify the DOH of the presence of those diseases within specified timeframes.

The bill specifies that, regarding the uterine fibroid research database, "the information required to be included under this subsection is subject to s. 381.0031, F.S." *See "Constitutional Issues."*

Section 2 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.

[11] Rule 64D-3.029, F.A.C.

E. Other Constitutional Issues:

This bill appears to expand, by reference, the existing public records exemption in s. 381.0031(6), F.S., by including the personal identifying information of women diagnosed with or treated for fibroids. Article I, section 24(c) of the Florida Constitution requires that any law that creates or expands a public records exemption must be passed in a separate bill and must state with specificity the public necessity justifying the exemption. A public records exemption that is expanded to include additional records or information is considered a substantial amendment and, therefore, must be enacted through a stand-alone public records exemption bill that includes a public necessity statement. Such a bill must pass by a two-thirds vote of the members present and voting in each house of the Legislature.

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:

CS/SB 864 is a public records exemption bill related to SB 196. CS/SB 864 also provides an effective date of July 1, 2026. If SB 196 were to take effect without the enactment of CS/SB 864 or similar legislation, the personal identifying information collected in the uterine fibroid research database would become publicly available and would not be protected by a public records exemption. To avoid this outcome, this bill should be amended to make its effective date contingent upon CS/SB 864 or similar legislation taking effect, if such legislation is adopted in the same legislative session or an extension thereof.

VIII. Statutes Affected:

This bill substantially amends 381.9312 of the Florida Statutes.

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.

514292

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete lines 17 - 24

and insert:

~~(c) The database may not include any personal identifying information of women diagnosed with or treated for uterine fibroids.~~

Section 2. This act shall take effect on the same date that SB 864 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension

514292

thereof and becomes a law.

================ 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:

database; amending s. 381.9312, F.S.; deleting a prohibition on the inclusion of personal identifying information in the uterine fibroid research database; providing a contingent effective date.

By Senator Sharief

35-00600-26 2026196__

A bill to be entitled

An act relating to the uterine fibroid research database; amending s. 381.9312, F.S.; requiring the Department of Health to include uterine fibroids in a specified list of diseases it issues; providing applicability; deleting a prohibition on the inclusion of personal identifying information in the database; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 381.9312, Florida Statutes, is amended to read:

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

(2) UTERINE FIBROID RESEARCH DATABASE.—

(c) The department shall include uterine fibroids in the list of diseases issued under s. 381.0031(4) ~~The database may not include any personal identifying information of women diagnosed with or treated for uterine fibroids~~.

The information required to be included under this subsection is subject to s. 381.0031.

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

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 1574
INTRODUCER:	Senators Bracy Davis and Sharief
SUBJECT:	Newborn Screenings
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1574 creates "Mattie's Law." The bill requires the Department of Health (DOH) to:

- Adopt rules that, beginning January 1, 2027, require each newborn be screened for biliary atresia (BA) using the blood specimen collected for newborn screenings.
- By October 1, 2026, implement a statewide public health education campaign to increase public awareness and understanding of BA and its associated risks.
- Consult with the Genetics and Newborn Screening Advisory Council before adopting rules regarding screening methods, follow-up procedures, and the inclusion of additional conditions in the screening program.

The bill also creates s. 395.3043, F.S., to require hospitals that provide birthing services to screen newborns for BA pursuant to the new requirement.

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

II. Present Situation:

Biliary Atresia

BA is a serious condition that is estimated to occur in one out of every 12,000 babies in the United States and in which a baby's bile ducts are blocked and cannot send bile from their liver to their small intestine. Bile is a substance a baby's liver produces that carries waste products to their intestines. Bile also helps a baby's intestines digest and absorb vital nutrients. BA affects babies in their first few months of life and can quickly lead to severe liver damage without prompt treatment.

A slowdown or stalling of bile flow (cholestasis) affects a baby's liver and all the organs and tissues surrounding it. Bile clogs up in a baby's liver and causes scarring that can prevent the

baby's liver from working normally. Also, an afflicted baby's intestines cannot receive the bile needed to break down nutrients and support growth.[1]

BA has a well-established treatment which can delay or even avoid the need for liver transplant. This treatment, Kasai portoenterostomy (KP), directly connects the intestines to the liver to restore bile flow. A critical factor predicting KP outcomes is the time at which the operation is performed. KPs performed before 30 to 45 days of life have the greatest chances of delaying or avoiding liver transplant. Unfortunately, in the United States, without screening, the average age at the time of KP is after 60 days of life and there have been no recent improvements.[2]

One screening strategy for BA is a two-stage screening that looks at serum bilirubin measurements. A study on four Houston, Texas, area hospitals over a 15-month period looked at bilirubin measurements in 11,636 infants and considered newborns to be positive if they had a direct or conjugated bilirubin concentration higher than the 95th percentile. In the second stage, an infant was considered to be positive if he or she had rising concentrations of bilirubin at or before the first well-child visited. Of the 11 infants that tested positive in both stages, two had BA. Of the two infants with BA, the KP was unable to be performed on one of them due to severe congenital heart disease. After the KP procedure, the other infant's bilirubin concentration normalized within three months and the patient survived, transplant-free past two years of age.[3]

Florida's Newborn Screening Program

Established in s. 383.14, F.S., Florida's Newborn Screening Program requires the DOH to promote the screening of all newborns born in Florida for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the DOH. The primary method of screening is a blood sample which is collected on a specimen card and submitted to the State Public Health Laboratory for testing.[4] The State Public Health Laboratory is required to send a written report with the results of the newborn screening to the submitting entity within five calendar days after receipt of the specimen.[5] Currently, the screening program screens for 37 core conditions and may detect an additional 23 secondary conditions.[6]

III. Effect of Proposed Changes:

SB 1574 creates "Mattie's Law." The bill amends s. 383.14, F.S., to require the DOH to:

- Adopt rules that, beginning January 1, 2027, require each newborn be screened for BA using the blood specimen collected for newborn screenings.

[1] *Biliary Atresia*, Clevland Clinic, last updated Aug. 9, 2023, available at https://my.clevelandclinic.org/health/diseases/21076-biliary-atresia, (last visited Feb. 5, 2026).
[2] Rabbani T, Guthery SL, Himes R, Shneider BL, Harpavat S. Newborn Screening for Biliary Atresia: a Review of Current Methods. Curr Gastroenterol Rep. 2021 Nov 24;23(12):28. doi: 10.1007/s11894-021-00825-2. PMID: 34817690; PMCID: PMC8651301.
[3] Newborn Bilirubin Screening for Biliary Atresia, August 11, 2016, N. Engl. J. Med. 2016;375:605-606, VOL. 375 NO.6.
[4] Rule 64C-7.002, F.A.C.
[5] Rule 64C-7.005, F.A.C.
[6] For a full list of conditions, see https://floridanewbornscreening.com/conditions/core-secondary-conditions/, (last visited Feb. 5, 2026).

- By October 1, 2026, implement a statewide public health education campaign to increase public awareness and understanding of BA and its associated risks. The campaign, at a minimum, must:
  - Educate new and expecting parents on the symptoms of BA and the importance of early diagnosis; and
  - Provide guidance to physicians, physician assistants, and nurses on strategies for identifying BA in infants and the risks of delayed treatment.
- Consult with the Genetics and Newborn Screening Advisory Council before adopting rules regarding screening methods, follow-up procedures, and the inclusion of additional conditions in the screening program.

The bill also creates s. 395.3043, F.S., to require hospitals that provide birthing services to screen newborns for BA pursuant to the new requirement.

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 383.14 of the Florida Statutes.

This bill creates section 395.3043 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 Bracy Davis

15-00087A-26 20261574__

A bill to be entitled

An act relating to newborn screenings; providing a short title; amending s. 383.14, F.S.; revising rulemaking procedures; requiring that newborns, beginning on a specified date, be screened for biliary atresia; requiring the Department of Health to consult with the Genetics and Newborn Screening Advisory Council before adopting certain rules; requiring the department, by a specified date, to implement a certain education campaign relating to biliary atresia; creating s. 395.3043, F.S.; requiring hospitals that provide birthing services to screen for biliary atresia in a specified manner; providing an effective date.

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

Section 1. This act may be cited as "Mattie's Law."

Section 2. Paragraph (a) of subsection (2) of section 383.14, Florida Statutes, is amended, paragraph (c) is added to that subsection, and paragraph (i) is added to subsection (3) of that section, to read:

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

(2) RULES.—

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

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

2. Be tested for any condition included on the federal Recommended Uniform Screening Panel which the council advises the department should be included under the state's screening program. After the council recommends that a condition be included, the department shall submit a legislative budget request to seek an appropriation to add testing of the condition to the newborn screening program. The department shall expand statewide screening of newborns to include screening for such conditions within 18 months after the council renders such advice, if a test approved by the United States Food and Drug Administration or a test offered by an alternative vendor is available. If such a test is not available within 18 months after the council makes its recommendation, the department must ~~shall~~ implement such screening as soon as a test offered by the United States Food and Drug Administration or by an alternative vendor is available;

3. At the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary; ~~and~~

4. Beginning January 1, 2027, be screened for biliary atresia by testing the newborn's direct bilirubin levels using the blood specimen collected for newborn screenings; and

5.~~4.~~ Subject to legislative appropriation, beginning January 1, 2027, be screened for Duchenne muscular dystrophy.

(c) The department shall consult with the Genetics and Newborn Screening Advisory Council before adopting rules regarding screening methods, follow-up procedures, and the

inclusion of additional conditions in the screening program.

(3) DEPARTMENT OF HEALTH; POWERS AND DUTIES.—The department shall administer and provide certain services to implement the provisions of this section and shall:

(i) By October 1, 2026, implement a statewide public health education campaign to increase public awareness and understanding of biliary atresia and its associated risks. The campaign shall, at a minimum:

1. Educate new and expecting parents on the symptoms of biliary atresia and the importance of early diagnosis.

2. Provide guidance to health care providers licensed under chapters 458, 459, and 464 on strategies for identifying biliary atresia in infants and the risks of delayed treatment.

All provisions of this subsection must be coordinated with the provisions and plans established under this chapter, chapter 411, and Pub. L. No. 99-457.

Section 3. Section 395.3043, Florida Statutes, is created to read:

395.3043 Mandatory newborn screening for biliary atresia.—A hospital that provides birthing services shall screen newborns for biliary atresia as required in s. 383.14(2)(a)4.

Section 4. This act shall take effect July 1, 2026.

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 878
INTRODUCER:	Senator Yarborough
SUBJECT:	Clinical Laboratory Personnel
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Pre-meeting**
2.			AHS	
3.			RC	

I. Summary:

SB 878 requires the Department of Health (DOH) to deem applicants for licensure as a clinical laboratory technologist or technician as having satisfied Florida's minimum licensure qualifications if the applicant meets specified federal Clinical Laboratory Improvement Amendments (CLIA) personnel qualification requirements for high complexity or moderate complexity testing. The bill eliminates state specific regulations for various specialty licensure categories.

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

II. Present Situation:

Florida Regulation of Clinical Laboratory Personnel

A clinical laboratory is a facility in which human specimen is tested to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition. Services performed in clinical labs include the examination of:

- Fluids or other materials taken from the human body;
- Tissue taken from the human body; and
- Cells from individual tissues or fluid taken from the human body.[1]

The DOH, through the Division of Medical Quality Assurance, and the Board of Clinical Laboratory Personnel (Board), regulates clinical laboratory personnel, trainees, and training programs under part I of ch. 483, F.S., ch. 456, F.S., and ch. 64B3-1 through 64B3-13, F.A.C.

[1] Section 483.803(2), F.S.

Florida licensure for clinical laboratory personnel is subdivided by both level of licensure and specialty of practice. Individuals may be licensed as a director, supervisor, technologist, technician, or public health laboratory scientist. In state fiscal year 2024-2025, Florida had 21,549 licensed clinical laboratory personnel, including 12,683 licensed technologists and 2,031 licensed technicians.[2] At each level, a licensee may hold one or more specialty licenses as provided in ch. 64B3-5, F.A.C.

Pursuant to ss. 483.809 and 483.823, F.S., the Board has adopted the minimum education, training, experience, and examination requirements for each level of licensure and for each specialty sought. Each licensure pathway requires national certification appropriate to the level of licensure and specialty area(s) of practice. The Board recognizes more than 40 certification types issued by 16 national certifying bodies.[3]

Florida is one of 10 states that require state licensure for clinical laboratory personnel.[4] In the remaining states, personnel qualifications are generally determined by the laboratory director in accordance with federal Clinical Laboratory Improvement Amendments (CLIA) requirements or, when applicable, a state laboratory licensure program.

Rule 64B3-5.003(2), F.A.C., requires applicants for clinical laboratory technologist licensure to meet CLIA personnel qualification standards for high complexity testing.
Rule 64B3-5.004(2), F.A.C., requires applicants for clinical laboratory technician licensure to meet CLIA personnel qualification standards for moderate complexity testing; however, the rule also permits technicians who meet CLIA standards for high complexity testing to perform high complexity testing. The DOH does not track which technician licensees are authorized to perform high complexity testing. The Agency for Health Care Administration (AHCA) surveys federally certified clinical laboratories and verifies that personnel licensure is appropriate for the testing performed.[5]

Federal CLIA Oversight and Personnel Qualifications

The U.S. Centers for Medicare & Medicaid Services (CMS) regulates human laboratory testing, other than research testing, through the Clinical Laboratory Improvement Amendments (CLIA) certification program. Federal personnel standards applicable to individuals working in CLIA-certified laboratories are set forth in 42 C.F.R. part 493, subpart M.

Newly amended CLIA personnel standards that took effect in 2024[6] provide that an individual performing high complexity testing, regardless of specialty, is deemed qualified if the individual meets one of several specified pathways, including being a licensed allopathic, osteopathic, or podiatric physician (M.D., D.O., or D.P.M.); holding a doctoral, master's, or bachelor's degree in chemical, biological, clinical, or medical laboratory science, or medical technology, from an accredited institution; holding an associate degree in laboratory science or medical laboratory

[2] Department of Health, *Senate Bill 878 Bill Analysis* (Dec. 15, 2025) (on file with the Senate Committee on Health Policy).
[3] *Id.*
[4] *Id*.
[5] *Id*.
[6] Clinical Laboratory Improvement Amendments of 1988 (CLIA) Fees; Histocompatibility, Personnel, and Alternative Sanctions for Certificate of Waiver Laboratories, 88 Fed. Reg. 89,976 (Dec. 28, 2023) (final rule) (effective Jan. 27, 2024).

technology from an accredited institution; completing an official U.S. military medical laboratory procedures training course of at least 50 weeks and holding the enlisted occupational specialty of Medical Laboratory Specialist (Laboratory Technician); or completing at least 60 semester hours (or equivalent) from an accredited institution with specified coursework in chemistry, biology, and laboratory sciences, together with completion of a laboratory training program and at least three months of work experience.[7]

With respect to moderate complexity testing, the amended regulations provide that an individual is deemed qualified if the individual meets the qualifications for high complexity testing; or has a high school diploma (or equivalent) and has successfully completed an official U.S. military medical laboratory procedures training course of at least 50 weeks and held the enlisted occupational specialty of Medical Laboratory Specialist (Laboratory Technician); or has a high school diploma (or equivalent) and documentation of laboratory training appropriate for the testing performed.

Florida licensure requirements exceed the federal CLIA baseline by basing qualifications on the specialty of testing performed, requiring national certification, and requiring applicants to have completed an approved training program or to demonstrate a specified amount of pertinent experience in one or more specialties.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 483.815, F.S., to require an applicant who qualifies under the new deeming pathways in Section 2 of the bill to provide proof of qualification, submit to the existing background screening requirement in s. 456.0135, F.S., and pay the fees already required under s. 483.807, F.S., to be eligible for licensure.

Section 2 of the bill amends s. 483.823, F.S., to create two deeming pathways for licensure. Under the bill:

- A technologist or technician applicant who satisfies 42 C.F.R. s. 493.1489 is deemed to have satisfied Florida's minimum qualifications to perform high complexity testing as a technologist or technician.
- A technician applicant who satisfies 42 C.F.R. s. 493.1423 is deemed to have satisfied Florida's minimum qualifications to perform moderate complexity testing as a technician.

Beginning July 1, 2026, the bill provides that new applicants would only need to demonstrate compliance with the applicable CLIA personnel standards to qualify for Florida licensure as a technologist or technician. Currently licensed technologists and technicians would be considered qualified under federal regulations because Florida licensure requirements already exceed the federal CLIA baseline.

The Board will need to update multiple rules to implement the bill using existing rulemaking authority under s. 483.805(4), F.S.

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

[7] *Supra* note 3.

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 anticipates a negative fiscal impact of $55,680 in non-recurring contracted services funding to update the Licensing and Enforcement Information Database System and Online Service Portal (Versa Online) to modify the processing of all clinical laboratory applications.[8]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[8] *Id*.

VIII. Statutes Affected:

This bill substantially amends sections 483.815 and 483.823 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 Yarborough

4-01276-26 2026878__

A bill to be entitled

An act relating to clinical laboratory personnel; amending s. 483.815, F.S.; requiring that an applicant who qualifies for licensure under specified provisions provide proof of such qualification and pay the required fees to be eligible for licensure; amending s. 483.823, F.S.; requiring that applicants for licensure as a technologist or technician who meet specified criteria be deemed to have satisfied minimum qualifications for licensure to perform high or moderate complexity testing as a technologist or technician, as applicable; providing an effective date.

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

Section 1. Section 483.815, Florida Statutes, is amended to read:

483.815 Application for clinical laboratory personnel license.—

(1) An application for a clinical laboratory personnel license must ~~shall~~ be made under oath on forms provided by the department and must ~~shall~~ be accompanied by payment of fees as provided by this part. Applicants for licensure must also submit to background screening in accordance with s. 456.0135. A license may be issued authorizing the performance of procedures of one or more categories.

(2) An applicant who qualifies for licensure under s. 483.823(3) or (4) must provide proof of such qualification,

submit to background screening in accordance with s. 456.0135, and pay the fees required under s. 483.807 to be eligible for licensure.

Section 2. Subsections (3) and (4) are added to section 483.823, Florida Statutes, to read:

483.823 Qualifications of clinical laboratory personnel.—

(3) Except as otherwise provided in s. 483.812, a technologist or technician applicant for licensure who satisfies the requirements in 42 C.F.R. s. 493.1489 to perform high complexity testing is deemed to have satisfied the minimum qualifications for licensure under this part to perform high complexity testing as a technologist or technician in this state.

(4) Except as otherwise provided in s. 483.812, a technician applicant for licensure who satisfies the requirements in 42 C.F.R. s. 493.1423 to perform moderate complexity testing is deemed to have satisfied the minimum qualifications for licensure under this part to perform moderate complexity testing as a technician in this state.

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

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 1092
INTRODUCER:	Senator Massullo
SUBJECT:	Podiatric Medicine
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Pre-meeting**
2.			AHS	
3.			RC	

I. Summary:

SB 1092 limits the existing controlled substance prescribing continuing education requirement to podiatric physicians registered with the U.S. Drug Enforcement Administration and authorized to prescribe controlled substances, exempting podiatric physicians who do not prescribe controlled substances.

The bill authorizes podiatric physicians to perform stem cell therapies that have not been approved by the U.S. Food and Drug Administration (FDA) when used for orthopedic conditions, wound care, or pain management. The bill establishes standards for the manufacturing and storage of stem cells and requires a podiatric physician to obtain a signed informed consent form from a patient before administering any such therapy.

The bill requires that written notice be provided to a patient prior to the performance of stem cell therapy, disclosing that the therapy is not approved by the FDA. This disclosure must also be included in any advertisement for the therapy. The bill directs the Board of Podiatric Medicine to adopt rules to implement the bill.

The bill takes effect July 1, 2026.

II. Present Situation:

Podiatric Physicians

Podiatric physicians are licensed to practice podiatric medicine. Section 461.003, F.S., defines the "practice of podiatric medicine" to mean the diagnosis or medical, surgical, palliative, and mechanical treatment of ailments of the human foot and leg. Surgical treatment is anatomically limited to the area below the anterior tibial tubercle. The definition specifies that the practice

includes amputation of the toes or other parts of the foot but does not include amputation of the foot or leg in its entirety.

Podiatrists are regulated by the Board of Podiatric Medicine (Board) within the Department of Health (DOH) under ch. 461, F.S., which establishes minimum requirements for the safe practice of podiatric medicine. At the end of state fiscal year 2024-2025, there were 1,589 in-state and 312 out-of-state podiatric physicians licensed by the state of Florida.[1]

Licensed podiatrists are subject to discipline under ch. 456, F.S., and the podiatrist-specific grounds in ch. 461, F.S. The DOH and the Board may take action for rule violations, fraud, and other enumerated misconduct. The Board's implementing rules are codified in Rule Chapter 64B18, F.A.C., addressing matters such as licensure and renewal, continuing medical education, advertising, and disciplinary grounds.

Prescribing Authority

Current law authorizes a podiatric physician to prescribe drugs that relate specifically to their authorized scope of practice within the definition of "practice of podiatric medicine."[2] To become authorized to prescribe controlled substances to treat chronic nonmalignant pain, a podiatrist must designate himself or herself as a controlled substance prescribing practitioner on his or her practitioner profile and comply with all requirements specified in s. 456.44, F.S., and in rules established by the Board of Podiatric Medicine.[3] Federal law requires a podiatrist to register with the U.S. Drug Enforcement Administration (DEA) before he or she may lawfully dispense[4] a controlled substance.[5]

As a condition to receiving DEA registration, a podiatrist must complete at least 8 hours of training on the treatment and management of patients with opioid or other substance use disorders, the safe pharmacological management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with or at risk of developing opioid or other substance use disorders.[6]

Federal law makes it unlawful for a registrant to dispense a controlled substance not authorized by his or DEA registration to another registrant or other authorized person.[7] A registrant who engages in such unlawful practice is subject to a civil penalty of not more than $25,000 and to criminal prosecution.[8]

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[1] Division of Medical Quality Assurance, *Annual Report and Long-Range Plan: Fiscal Year 2024-2025*, at 29 https://www.floridahealth.gov/wp-content/uploads/2026/01/2025.10.31.FY24-25MQAAR-FINAL1-1.pdf (last visited Feb. 6, 2026).
[2] Section 461.003(5), F.S.
[3] Section 456.44(2), F.S., Rule 64B18-23.002(2)(g), F.A.C.
[4] Federal law relating to drug abuse prevention and control states that the term "dispense" means "to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery. The term "dispenser" means a practitioner who so delivers a controlled substance to an ultimate user or research subject. 21 U.S.C. § 802(10).
[5] 21 U.S.C. § 822(a)(2); 21 C.F.R. § 1301.11(a).
[6] 21 U.S.C. § 823(m)(1).
[7] 21 U.S.C. § 842(a)(2).
[8] 21 U.S.C. § 842(c).

Continuing Education Requirements

Current law requires podiatric physicians to complete 40 hours of continuing education (CE) as a part of the biennial licensure renewal process, and at least two of those hours must be on the safe and effective prescribing of controlled substances. All podiatrists, including those who are not authorized to prescribe controlled substances, are required to take the CE on safe and effective prescribing of controlled substances. The Board must approve the criteria for CE programs or courses.[9]

Overview of Stem Cells and Stem Cell Therapy

Stem cells are undifferentiated cells with the unique ability to develop into specialized cell types and to divide indefinitely under certain conditions.[10] They are broadly classified as either embryonic or adult (somatic) stem cells. Embryonic stem cells, derived from early-stage embryos, are pluripotent and capable of differentiating into nearly all cell types in the human body. Adult stem cells are more limited in scope and typically generate only cell types consistent with their tissue of origin.

In 2007, researchers developed induced pluripotent stem cells (iPSCs), a type of adult stem cell reprogrammed to exhibit pluripotency.[11] These iPSCs have opened new frontiers in regenerative medicine by offering a potential alternative to the use of embryonic stem cells.

Stem cell therapy involves administering stem cells or derivatives to repair, replace, or regenerate human tissues. While hematopoietic stem cell transplants for blood disorders are established treatments, many other stem cell therapies remain experimental and are not approved by the FDA for routine clinical use.[12]

Federal Regulation of Human Cells, Tissues, and Cellular and Tissue-Based Products

The FDA regulates stem cell products that meet the definition of human cells, tissues, or cellular and tissue-based products (HCT/Ps) through its Center for Biologics Evaluation and Research (CBER).[13] CBER's authority derives from the Public Health Service Act (42 U.S.C. § 264) and the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 301 et seq.). Applicable federal regulations are found primarily in 21 C.F.R., part 1271.

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[9] Section 461.007(3), F.S., and Rule 64B18-17, F.A.C. By rule, the Board approves of all CE programs sponsored or approved by the American Podiatric Medical Association, the Council on Podiatric Medical Education, the American Medical Association, the American Osteopathic Association, and the American Hospital Association. Rule 64B18-17.002(1), F.A.C.

[10] Department of Health, Senate Bill 1617 *Legislative Analysis* (Mar. 19, 2025) (on file with the Senate Committee on Health Policy).

[11] *Id*.

[12] Harvard Stem Cell Institute, *Frequently Asked Questions: Stem Cell Therapies*, *available at*: https://www.hsci.harvard.edu/faq/stem-cell-therapies (last visited Feb. 4, 2026).

[13] U.S. Food & Drug Administration, *Center for Biologics Evaluation and Research (CBER)*, *available at*: https://www.fda.gov/about-fda/fda-organization/center-biologics-evaluation-and-research-cber (last visited Feb. 4, 2026).

Products that meet all of the criteria under 21 C.F.R. § 1271.10 – commonly referred to as "361 HCT/Ps" – are subject to less stringent oversight. To qualify, the product must be:

- Minimally manipulated;
- Intended solely for homologous use;
- Not combined with another article (except for certain preservatives or water); and
- Either non-systemic and not dependent on the metabolic activity of living cells for its primary function, or used autologously or in a first- or second-degree blood relative.

Products that do not meet these criteria are classified as "351 HCT/Ps" and are regulated as biological drugs. These products require premarket approval through the FDA's Investigational New Drug (IND) and Biologics License Application (BLA) pathways, under 21 C.F.R., parts 312 and 600–680.

Enforcement and Oversight by FDA

The FDA requires establishments that manufacture or manipulate HCT/Ps to register with CBER and to comply with current Good Tissue Practices (cGTPs) under 21 C.F.R. part 1271, subpart D.[14] These practices are designed to prevent the introduction or transmission of communicable diseases. The FDA conducts inspections, issues warning letters, and may pursue civil or criminal enforcement actions against facilities or providers offering unapproved or noncompliant stem cell therapies.

The FDA has issued warnings about the widespread marketing of unapproved regenerative medicine products, noting that approval is granted only after rigorous evaluation in clinical trials to ensure safety and efficacy.[15] The FDA has received reports of serious adverse events associated with unapproved regenerative medicine therapies, including blindness, tumor formation, and infections.[16] Consumers are advised to exercise caution and are encouraged to report any adverse effects or file complaints related to these products directly to the FDA.

Regulation by the Florida Boards of Medicine and Osteopathic Medicine

The Florida Board of Medicine (BOM), under the DOH, is responsible for licensing, regulating, and disciplining medical doctors, a.k.a. allopathic physicians, pursuant to ch. 458, F.S. The Board of Osteopathic Medicine (BOOM), pursuant to ch. 459, F.S., exercises the same authority for osteopathic physicians.

On July 1, 2025, a new law took effect authorizing allopathic and osteopathic physicians to perform stem cell therapies that have not been approved by the FDA when used for orthopedic

[14] *See also* U.S. Department of Health & Human Services, *Current Good Tissue Practice (CGTP) and Additional Requirements for Manufacturers of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps)*, *available a*t: https://www.hhs.gov/guidance/document/current-good-tissue-practice-cgtp-and-additional-requirements-manufacturers-human-cells (last visited Feb. 6, 2026).
[15] U.S. Food & Drug Administration, *Important Patient and Consumer Information About Regenerative Medicine Therapies*, *available at*: https://www.fda.gov/vaccines-blood-biologics/consumers-biologics/important-patient-and-consumer-information-about-regenerative-medicine-therapies (last visited Feb. 4, 2026).
[16] *Id.*

conditions, wound care, or pain management.[17] Sections 458.3245 and 459.0127, F.S., establish standards for the manufacturing and storage of stem cells and procedures for allopathic physician and osteopathic physicians, respectively, to perform stem cell therapy.

Allopathic and osteopathic physicians are exempt from the requirements in those sections if they perform stem cell therapy on behalf of an institution accredited by:

- The Foundation for the Accreditation of Cellular Therapy;
- The Blood and Marrow Transplant Clinical Trials Network;
- The Association for the Advancement of Blood and Biotherapies; or
- An entity with expertise in stem cell therapy as determined by the DOH.

The DOH reports that it does not have rulemaking authority or a panel of experts to determine additional entities with stem cell expertise.[18] The 2025 law delegates rulemaking authority to the BOM and BOOM.[19] The Boards have formed a workgroup to discuss if any additional entities with expertise should be identified. The workgroup will make a recommendation to the Boards for consideration of a proposed rule.

III. Effect of Proposed Changes:

Section 1 amends s. 461.007, F.S., to establish that only podiatric physicians who are registered with the DEA and who are authorized to prescribe controlled substances pursuant to 21 U.S.C. s. 822, are required to complete a minimum of two hours of continuing education related to the safe and effective prescribing of controlled substances as a condition of biennial licensure renewal. The bill eliminates the requirement for podiatric physicians who do not prescribe controlled substances to complete such training within the 40 hours of continuing education otherwise required for license renewal.

Section 2 creates s. 461.011, F.S., to authorize podiatric physicians to perform stem cell therapies that are not approved by the FDA and to impose requirements relating to the manufacture, use, notice, consent, and oversight of such therapies. This new section mirrors ss. 458.3245 and 459.0127, F.S., which provide the same authorization for allopathic and osteopathic physicians.

Subsection (1) of that section provides legislative findings and intent, recognizing the potential of stem cell therapies to advance medical treatment and improve patient outcomes. This subsection emphasizes the importance of using ethically sourced stem cells and expresses the intent to prohibit the use of stem cells derived from aborted fetuses. Instead, the bill encourages the use of adult stem cells, umbilical cord blood, and other ethically obtained human cells, tissues, or cellular or tissue-based products.

Subsection (2) of that section defines key terms used throughout the section:

- "Human cells, tissues, or cellular or tissue-based products" articles containing or consisting of human cells or tissues that are intended for implantation, transplantation, infusion, or

[17] Ch. 2025-185, Laws of Fla.
[18] Department of Health, *Senate Bill 1092 Legislative Bill Analysis* (Jan. 15, 2026) (on file with the Senate Committee on Health Policy).
[19] Sections 458.3245(10) and 459.0127(10), F.S.

transfer into a human recipient. The subsection also lists exclusions from that definition, including vascularized human organs, whole blood and blood derivatives, secreted or extracted products (except semen, which is a human cell, tissue, or cellular-based tissue product under the bill), certain minimally manipulated bone marrow products, ancillary products used in manufacturing, non-human-derived tissues, in vitro diagnostic products, and blood vessels recovered with organs for transplantation.

- "Minimally manipulated" is defined in two parts: for structural tissue, it means processing that does not alter the original relevant characteristics of the tissue relating to reconstruction, repair, or replacement; for cells or nonstructural tissues, it means processing that does not alter the relevant biological characteristics of the cells or tissues.
- "Physician" is defined as a podiatric physician licensed under ch. 461, F.S., acting within the scope of his or her employment.
- "Stem cell therapy" is defined as a treatment involving the use of afterbirth placental perinatal stem cells, or human cells, tissues, or cellular or tissue-based products, which complies with the regulatory requirements provided in this section, and explicitly excludes any treatment or research using cells or tissues derived from a fetus or embryo following an abortion.

Subsection (3) of that section authorizes podiatric physicians to perform stem cell therapy not approved by the FDA, if the therapy is used for treatment or procedures within the scope of the physician's practice and is limited to the fields of orthopedics, wound care, or pain management.

Subsection (3) also establishes requirements relating to the source and handling of stem cells used in such therapy. Stem cells used by a physician must be obtained from a facility that is registered and regulated by the FDA and that is certified or accredited by the National Marrow Donor Program, the World Marrow Donor Association, the Association for the Advancement of Blood and Biotherapies, or the American Association of Tissue Banks. In addition, the stem cells must be included in a post-thaw viability analysis report for the product lot, which must be provided to the physician before use with a patient, and the stem cells must contain viable or live cells as demonstrated by that analysis.

Subsection (4) of that section requires podiatric physicians to obtain products from facilities that comply with applicable current good manufacturing practices for the collection, removal, processing, implantation, and transfer of stem cells or stem cell-containing products. These practices must be consistent with the requirements of the federal Food, Drug, and Cosmetic Act and relevant regulations under 21 C.F.R., part 1271.

Subsection (5) of that section requires a podiatric physician to include a specific written notice in any form of advertisement. The notice must state that he or she performs one or more stem cell therapies that have not yet been approved by the FDA and encourages patients to consult with their primary care provider before undergoing any such therapy. The notice must be legible and in a type size no smaller than the largest type size used in the advertisement.

Subsection (6) of that section requires a podiatric physician who conducts stem cell therapy pursuant to this section to obtain a signed consent form from the patient before performing the therapy. The consent form must be signed by the patient or, if the patient is not legally competent, the patient's representative, and must state, in language the patient or representative

may reasonably be expected to understand: the nature and character of the proposed treatment; that the proposed stem cell therapy has not yet been approved by the FDA; the anticipated results of the proposed treatment; the recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in recognized possible alternative forms of treatment, including nontreatment; and that the patient is encouraged to consult with his or her primary care provider before undergoing any stem cell therapy.

Subsection (7) of that section exempts two categories of podiatric physicians from the requirements of this section. The first exemption applies to a podiatric physician who has obtained FDA approval for an investigational new drug or device for the use of human cells, tissues, or cellular or tissue-based products. The second exemption applies to a podiatric physician who performs stem cell therapy under an employment or other contract on behalf of an institution that is certified by one of the following organizations: the Foundation for the Accreditation of Cellular Therapy; the Blood and Marrow Transplant Clinical Trials Network; the Association for the Advancement of Blood and Biotherapies; or another entity with expertise in stem cell therapy as determined by the Department of Health (DOH).

Subsection (8) of that section provides that a violation of any provision in the section may subject the podiatric physician to disciplinary action by the Board of Podiatric Medicine.

Subsection (9) of that section provides that a podiatric physician who willfully performs or procures the performance of stem cell therapy using cells or tissues derived from an aborted fetus, or who willfully sells, manufactures, distributes, or transfers any computer product created using human cells, tissues, or cellular or tissue-based products, commits a third-degree felony. In addition to criminal penalties, such conduct constitutes grounds for disciplinary action under ch. 461, F.S., and s. 456.072, F.S.

Subsection (10) of that section requires the Board of Podiatric Medicine to adopt rules to implement this section.

The bill authorizes podiatric physicians to administer stem cell therapies that have not been approved by the FDA. This action may expose podiatric physicians to federal regulatory enforcement. If a physician or supplier administers or distributes stem cell products in violation of FDA requirements, the FDA may take a range of enforcement actions, including issuing warning letters, initiating civil or criminal proceedings in coordination with the U.S. Department of Justice, seeking injunctions to prevent continued noncompliance, and disqualifying parties from participating in clinical investigations. In addition, the FDA has authority to issue orders for the retention, recall, destruction, or cessation of manufacturing of human cells, tissues, or cellular- and tissue-based products (HCT/Ps) when it has reasonable grounds to believe the products were manufactured in violation of applicable regulations.

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

The bill would have an indeterminate yet negative fiscal impact on state expenditures. The DOH will incur nonrecurring costs associated with rulemaking and updating systems. These costs can likely be absorbed within existing resources.

VI. Technical Deficiencies:

Section 461.003(4), F.S., defines the term "podiatric physician" as any person licensed to practice podiatric medicine pursuant to this chapter. "Practice of podiatric medicine" is also a defined term in that section. Lines 87-89 of this bill create a separate definition of "physician" within chapter 461, intending to capture a podiatric physician. An amendment should be considered to ensure statutory consistency and eliminate confusion.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 461.007 of the Florida Statutes.

This bill creates section 461.011 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.

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LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment

Delete lines 87 - 216

and insert:

(c) "Stem cell therapy" means a treatment involving the use of human cells, tissues, or cellular or tissue-based products which complies with the regulatory requirements provided in this section. The term does not include treatment or research using human cells or tissues that were derived from a fetus or an embryo after an abortion.

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(3)(a) A podiatric physician may perform stem cell therapy that is not approved by the United States Food and Drug Administration if such therapy is used for treatment or procedures that are within the scope of practice for such podiatric physician and the therapies are related to orthopedics, wound care, or pain management.

(b) To ensure that the retrieval, manufacture, storage, and use of stem cells used for therapies conducted under this section meet the highest standards, any stem cells used by a podiatric physician for therapy provided under this section must meet all of the following conditions:

1. Be retrieved, manufactured, and stored in a facility that is registered and regulated by the United States Food and Drug Administration.

2. Be retrieved, manufactured, and stored in a facility that is certified or accredited by one of the following entities:

a. The National Marrow Donor Program.

b. The World Marrow Donor Association.

c. The Association for the Advancement of Blood and Biotherapies.

d. The American Association of Tissue Banks.

3. Contain viable or live cells upon post-thaw analysis and be included in a post-thaw viability analysis report for the product lot which will be sent to the podiatric physician before use with the podiatric physician’s patient.

(c) A podiatric physician performing stem cell therapy may obtain stem cells for therapies from a facility engaging in the retrieval, manufacture, or storage of stem cells intended for

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human use under this section only if the facility maintains valid certification or accreditation as required by this subsection. Any contract or other agreement by which a podiatric physician obtains stem cells for therapies from such a facility must include the following:

1. A requirement that the facility provide all of the following information to the podiatric physician:

a. The name and address of the facility.

b. The certifying or accrediting organization.

c. The type and scope of certification or accreditation.

d. The effective and expiration dates of the certification or accreditation.

e. Any limitations or conditions imposed by the certifying or accrediting organization.

2. A requirement that the facility notify the podiatric physician within 30 days after any change in certification or accreditation status, including renewal, suspension, revocation, or expiration.

(4) In the performance of any procedure using or purporting to use stem cells or products containing stem cells, the podiatric physician shall use stem cell therapy products obtained from facilities that adhere to the applicable current good manufacturing practices for the collection, removal, processing, implantation, and transfer of stem cells, or products containing stem cells, pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. ss. 301 et seq.; 52 Stat. 1040 et seq.; and 21 C.F.R. part 1271, Human Cells, Tissues, and Cellular and Tissue-Based Products.

(5)(a) A podiatric physician who conducts stem cell therapy

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pursuant to this section shall include the following in any form of advertisement:

THIS NOTICE MUST BE PROVIDED TO YOU UNDER FLORIDA LAW. This podiatric physician performs one or more stem cell therapies that have not yet been approved by the United States Food and Drug Administration. You are encouraged to consult with your primary care provider before undergoing any stem cell therapy.

(b) The notice required under paragraph (a) must be clearly legible and in a type size no smaller than the largest type size used in the advertisement.

(6)(a) A podiatric physician who conducts stem cell therapy pursuant to this section shall obtain a signed consent form from the patient before performing the stem cell therapy.

(b) The consent form must be signed by the patient or, if the patient is not legally competent, the patient's representative and must state all of the following in language the patient or his or her representative may reasonably be expected to understand:

1. The nature and character of the proposed treatment.

2. That the proposed stem cell therapy has not yet been approved by the United States Food and Drug Administration.

3. The anticipated results of the proposed treatment.

4. The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment.

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5. That the patient is encouraged to consult with his or her primary care provider before undergoing any stem cell therapy.

(7) This section does not apply to the following:

(a) A podiatric physician who has obtained approval for an investigational new drug or device from the United States Food and Drug Administration for the use of human cells, tissues, or cellular or tissue-based products; or

(b) A podiatric physician who performs stem cell therapy under an employment or other contract on behalf of an institution certified or accredited by any of the following:

1. The Foundation for the Accreditation of Cellular Therapy.

2. The Blood and Marrow Transplant Clinical Trials Network.

3. The Association for the Advancement of Blood and Biotherapies.

(8) A violation of this section may subject the podiatric physician to disciplinary action by the board.

(9) A podiatric physician who willfully performs, or actively participates in, the following commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, and is subject to disciplinary action under this chapter and s. 456.072:

(a) Treatment or research using human cells or tissues derived from a fetus or an embryo after an abortion; or

(b) The sale, manufacture, or distribution of computer products created using human cells, tissues, or cellular or tissue-based products.

(10) The board may adopt rules necessary to implement this

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section.

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

By Senator Massullo

11-00695-26 20261092__

A bill to be entitled

An act relating to podiatric medicine; amending s. 461.007, F.S.; requiring certain podiatric physicians, instead of all podiatric physicians, to complete specified continuing education; creating s. 461.011, F.S.; providing legislative findings and intent; defining terms; authorizing podiatric physicians to perform stem cell therapy not approved by the United States Food and Drug Administration under certain circumstances; specifying requirements for the stem cells that may be used by such podiatric physicians; requiring podiatric physicians who perform such therapies to use stem cell therapy products obtained from facilities that adhere to applicable current good manufacturing practices; requiring podiatric physicians to include a specified notice in any form of advertisement; specifying requirements for such notice; requiring podiatric physicians to obtain a signed consent form from the patient or his or her representative before performing such stem cell therapy; specifying requirements for the consent form; providing applicability; providing for disciplinary action; providing criminal penalties; authorizing the Board of Podiatric Medicine to adopt rules; providing an effective date.

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

Section 1. Subsection (3) of section 461.007, Florida

Statutes, is amended to read:

461.007 Renewal of license.—

(3) The board may by rule prescribe continuing education, not to exceed 40 hours biennially, as a condition for renewal of a license, with a minimum of 2 hours of continuing education related to the safe and effective prescribing of controlled substances <u>for licensees who are registered with the United States Drug Enforcement Administration and authorized to prescribe controlled substance pursuant to 21 U.S.C. s. 822</u>. The criteria for such programs or courses shall be approved by the board.

Section 2. Section 461.011, Florida Statutes, is created to read:

<u>461.011 Stem cell therapy.—</u>

<u>(1) The Legislature recognizes the significant potential of stem cell therapies in advancing medical treatments and improving patient outcomes and further recognizes the need to ensure that such therapies are provided using stem cells obtained in an ethical manner that does not involve stem cells derived from aborted fetuses. It is the intent of the Legislature to foster medical innovation while upholding ethical standards that respect the sanctity of life. By encouraging the use of stem cell sources such as adult stem cells, umbilical cord blood, and other ethically obtained human cells, tissues, or cellular or tissue-based products, the state will advance regenerative medicine in a manner consistent with the values of this state.</u>

<u>(2) As used in this section, the term:</u>

<u>(a) "Human cells, tissues, or cellular or tissue-based</u>

products" means articles containing or consisting of human cells or tissues that are intended for implantation, transplantation, infusion, or transfer into a human recipient. The term does not include:

1. Vascularized human organs for transplantation;

2. Whole blood or blood components or blood derivative products;

3. Secreted or extracted human products, such as milk, collagen, and cell factors, other than semen;

4. Minimally manipulated bone marrow for homologous use and not combined with another article other than water, crystalloids, or a sterilizing, preserving, or storage agent, if the addition of the agent does not raise new clinical safety concerns with respect to the bone marrow;

5. Ancillary products used in the manufacture of human cells, tissues, or cellular or tissue-based products;

6. Cells, tissues, and organs derived from animals;

7. In vitro diagnostic products; or

8. Blood vessels recovered with an organ which are intended for use in organ transplantation and labeled "For use in organ transplantation only."

(b) "Minimally manipulated" means:

1. For structural tissue, processing that does not alter the original relevant characteristics of the tissue relating to the tissue's utility for reconstruction, repair, or replacement.

2. For cells or nonstructural tissues, processing that does not alter the relevant biological characteristics of cells or tissues.

(c) "Physician" means a podiatric physician licensed under

this chapter acting in the course and scope of his or her employment.

(d) "Stem cell therapy" means a treatment involving the use of afterbirth placental perinatal stem cells, or human cells, tissues, or cellular or tissue-based products, which complies with the regulatory requirements provided in this section. The term does not include treatment or research using human cells or tissues that were derived from a fetus or an embryo after an abortion.

(3)(a) A physician may perform stem cell therapy that is not approved by the United States Food and Drug Administration if such therapy is used for treatment or procedures that are within the scope of practice for such physician and the therapies are related to orthopedics, wound care, or pain management.

(b) To ensure that the retrieval, manufacture, storage, and use of stem cells used for therapies conducted under this section meet the highest standards, any stem cells used by a physician for therapy provided under this section must meet all of the following conditions:

1. Be retrieved, manufactured, and stored in a facility that is registered and regulated by the United States Food and Drug Administration.

2. Be retrieved, manufactured, and stored in a facility that is certified or accredited by one of the following entities:

a. The National Marrow Donor Program.

b. The World Marrow Donor Association.

c. The Association for the Advancement of Blood and

Biotherapies.

d. The American Association of Tissue Banks.

3. Contain viable or live cells upon post-thaw analysis and be included in a post-thaw viability analysis report for the product lot which will be sent to the physician before use with the physician's patient.

(c) A physician performing stem cell therapy may not obtain stem cells for therapies from a facility engaging in the retrieval, manufacture, or storage of stem cells intended for human use under this section unless the facility maintains valid certification or accreditation as required by this subsection. Any contract or other agreement by which a physician obtains stem cells for therapies from such a facility must include the following:

1. A requirement that the facility provide all of the following information to the physician:

a. The name and address of the facility.

b. The certifying or accrediting organization.

c. The type and scope of certification or accreditation.

d. The effective and expiration dates of the certification or accreditation.

e. Any limitations or conditions imposed by the certifying or accrediting organization.

2. A requirement that the facility notify the physician within 30 days after any change in certification or accreditation status, including renewal, suspension, revocation, or expiration.

(4) In the performance of any procedure using or purporting to use stem cells or products containing stem cells, the

physician shall use stem cell therapy products obtained from facilities that adhere to the applicable current good manufacturing practices for the collection, removal, processing, implantation, and transfer of stem cells, or products containing stem cells, pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. ss. 301 et seq.; 52 Stat. 1040 et seq.; and 21 C.F.R. part 1271, Human Cells, Tissues, and Cellular and Tissue-Based Products.

(5)(a) A physician who conducts stem cell therapy pursuant to this section shall include the following in any form of advertisement:

THIS NOTICE MUST BE PROVIDED TO YOU UNDER FLORIDA LAW. This physician performs one or more stem cell therapies that have not yet been approved by the United States Food and Drug Administration. You are encouraged to consult with your primary care provider before undergoing any stem cell therapy.

(b) The notice required under paragraph (a) must be clearly legible and in a type size no smaller than the largest type size used in the advertisement.

(6)(a) A physician who conducts stem cell therapy pursuant to this section shall obtain a signed consent form from the patient before performing the stem cell therapy.

(b) The consent form must be signed by the patient or, if the patient is not legally competent, the patient's representative and must state all of the following in language the patient or his or her representative may reasonably be

expected to understand:

1. The nature and character of the proposed treatment.

2. That the proposed stem cell therapy has not yet been approved by the United States Food and Drug Administration.

3. The anticipated results of the proposed treatment.

4. The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment.

5. That the patient is encouraged to consult with his or her primary care provider before undergoing any stem cell therapy.

(7) This section does not apply to the following:

(a) A physician who has obtained approval for an investigational new drug or device from the United States Food and Drug Administration for the use of human cells, tissues, or cellular or tissue-based products; or

(b) A physician who performs stem cell therapy under an employment or other contract on behalf of an institution certified or accredited by any of the following:

1. The Foundation for the Accreditation of Cellular Therapy.

2. The Blood and Marrow Transplant Clinical Trials Network.

3. The Association for the Advancement of Blood and Biotherapies.

4. An entity with expertise in stem cell therapy as determined by the department.

(8) A violation of this section may subject the physician to disciplinary action by the board.

(9) A physician who willfully performs, or actively participates in, the following commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, and is subject to disciplinary action under this chapter and s. 456.072:

(a) Treatment or research using human cells or tissues derived from a fetus or an embryo after an abortion; or

(b) The sale, manufacture, or distribution of computer products created using human cells, tissues, or cellular or tissue-based products.

(10) The board may adopt rules necessary to implement this section.

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

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 1032
INTRODUCER:	Senator Calatayud
SUBJECT:	Medical Marijuana
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1032 amends s. 381.986, F.S., to increase the time before a qualified patient is required to see his or her physician to be recertified to use medical marijuana from 30 weeks to 104 weeks and to require a qualified patient to renew his or her medical marijuana use registry identification card (ID card) biennially rather than annually. Additionally, the bill exempts any veteran who was honorably discharged from the United States Armed Forces from paying a fee for the issuance, replacement, or renewal of an ID card.

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

II. Present Situation:

Medical Marijuana Use Certification and Registry Identification Cards

In order to be able to legally access and use medical marijuana in Florida, a qualified patient[1] must be certified to use medical marijuana by a qualified physician,[2] be added to the medical marijuana use registry (registry) by that physician, and be issued an ID card. A qualified physician is authorized to certify a qualified patient to use medical marijuana after examining the patient in person and meeting other criteria established in s. 381.986(4), F.S. A qualified physician may only certify a patient to obtain up to three 70-day supplies of marijuana or six 35-day supplies of marijuana in a form for smoking at a time unless the qualified physician requests and receives an exception for that patient from the Department of Health (DOH).[3] Additionally, a qualified physician is also required to evaluate and re-certify the qualified patient for the use of medical marijuana at least once every 30 weeks.[4]

[1] Defined in s. 381.986(1)(m), F.S.
[2] Defined in s. 381.986(1)(n), F.S.
[3] Section 381.986(4)(f), F.S.
[4] Section 381.986(4)(g), F.S.

After a qualified physician issues a certification to a qualified patient, that physician is required to enter the contents of the certification into the registry[5] and then the qualified patient must apply to the DOH to be issued an ID card. Section 381.986(7), F.S., establishes requirements for ID cards including that ID cards must be renewed annually. Additionally, the DOH is authorized to charge a reasonable fee for the issuance, replacement, and renewal of ID cards, $10 of which must be allocated to the Division of Research at Florida Agricultural and Mechanical University (FAMU) per ID card issued.[6]

Currently, the DOH charges $75 for issuing or renewing an ID card and $15 dollars to replace an ID card.[7] Currently, the registry contains 932,747 patients with active ID cards, and the time required for processing an ID card application is five days with an additional five days for the printing of the ID card.[8]

III. Effect of Proposed Changes:

SB 1032 amends s. 381.986, F.S., to:

- Increase the time before a qualified patient is required to see his or her physician to be re-certified to use medical marijuana from 30 weeks (approximately seven months) to 104 weeks (two years);
- Increase the number of 70-day supplies of non-smokable marijuana that a qualified physician may certify a qualified patient to receive, from three to 10, which would mean a patient would not need a new certification of such supplies for up to 700 days (which is 30 days shy of two years);
- Increase the number of 35-day supplies of smokable marijuana that a qualified physician may certify a qualified patient to receive, from six to 20, which would mean a patient would not need a new certification of such supplies for up to 700 days; and
- Require a qualified patient to renew his or her ID card biennially rather than annually.

Additionally, the bill exempts any veteran who was honorably discharged from the United States Armed Forces from paying a fee for the issuance, replacement, or renewal of an ID card.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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[5] Section 381.986(4)(a)7.a., F.S.
[6] Section 381.986(7)(d), F.S. This statute provides that the $10 per card that is allocated to FAMU is for the purpose of educating minorities about marijuana for medical use and the impact of the unlawful use of marijuana on minority communities. No other purpose is provided.
[7] MMUR Identification Cards, Office of Medical Marijuana Use, available at https://knowthefactsmmj.com/patients/cards/#requirements, (last visited Feb. 6, 2026).
[8] Office of Medical Marijuana Use Weekly Update for January 30, 2026, available at https://knowthefactsmmj.com/wp-content/uploads/ommu_updates/2026/013026-OMMU-Update.pdf, (last visited Feb. 6, 2026)

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 1032 may have a significant indeterminate positive fiscal impact on qualified patients who may visit a qualified physician at a greatly reduced frequency to be re-certified and pay $75 to renew their ID cards every two years under the bill rather than every year. Additionally, SB 1032 may have a further positive fiscal impact on honorably discharged veterans who are no longer required to pay the initial $75 ID card fee and the annual ID card renewal fee.[9]

C. Government Sector Impact:

SB 1032 will likely have a significant negative fiscal impact on both the DOH and FAMU. This fiscal impact is largely caused by cutting in half the number of ID card renewal fees that the DOH will receive since qualified patients will only be required to renew their ID cards biennially rather than annually. Additionally, the state's Revenue Estimating Conference, when considering the fiscal impact of SB 1032, reviewed the impact of honorably discharged veterans being exempted from the ID card fee.[10]

The DOH is not required to charge a specific amount for issuing or renewing ID cards but rather may charge a "reasonable fee." Therefore, it is possible that the fiscal impact to the DOH could be mitigated should the DOH increase the fee amount to compensate for biennial renewals instead of annual. However, any increase in the fee amount will not

[9] The ID card fee is $75 but could be increased by DOH under current law, and that authority is not amended by the bill.
[10] Revenue Estimating Conference Report on SB 1032, Jan. 9, 2026, starting on p. 171, available at https://edr.state.fl.us/Content/conferences/revenueimpact/archives/2026/_pdf/page171-185.pdf (last visited Feb. 8, 2026).

mitigate the bill's negative impact to FAMU, because s. 381.986(7)(d), F.S., directs the DOH to allocate $10 of each ID card fee to FAMU regardless of the fee amount.

Taking into account the possibility for the DOH to increase the fee amount, the Revenue Estimating Conference considered SB 1032's fiscal impact to the DOH and FAMU, as displayed in the table below, based on two scenarios – maintaining the current $75 fee per card versus doubling the fee. Note that the impact to FAMU does not change from one scenario to the other, as explained above.

	Maintain $75 Per Card, Biennially (Except Honorably Discharged Veterans)		Charge $150 Per Card, Biennially (Except Honorably Discharged Veterans)	
State Fiscal Year	Impact to DOH	Impact to FAMU	Impact to DOH	Impact to FAMU
2026-27	($6 million)	($1 million)	$54.1 million	($1 million)
2027-28	($ 58.1 million)	($9.7 million)	($56.8 million)	($9.7 million)
2028-29	($7 million)	($1.2 million)	$53.9 million	($1.2 million)
2029-30	($58.6 million)	($9.8 million)	($56.9 million)	($9.8 million)
2030-31	($7.1 million)	($1.2 million)	$54.1 million	($1.2 million)

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 381.986 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.

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LEGISLATIVE ACTION

Senate . House

. . . . . .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraphs (f) and (g) of subsection (4) and paragraph (d) of subsection (7) of section 381.986, Florida Statutes, are amended to read:

381.986 Medical use of marijuana.—

(4) PHYSICIAN CERTIFICATION.—

(f) A qualified physician may not issue a physician

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certification for more than five ~~three~~ 70-day supply limits of marijuana or more than ten ~~six~~ 35-day supply limits of marijuana in a form for smoking. The department shall quantify by rule a daily dose amount with equivalent dose amounts for each allowable form of marijuana dispensed by a medical marijuana treatment center. The department shall use the daily dose amount to calculate a 70-day supply.

1. A qualified physician may request an exception to the daily dose amount limit, the 35-day supply limit of marijuana in a form for smoking, and the 4-ounce possession limit of marijuana in a form for smoking established in paragraph (14)(a). The request must ~~shall~~ be made electronically on a form adopted by the department in rule and must include, at a minimum:

a. The qualified patient's qualifying medical condition.

b. The dosage and route of administration that was insufficient to provide relief to the qualified patient.

c. A description of how the patient will benefit from an increased amount.

d. The minimum daily dose amount of marijuana that would be sufficient for the treatment of the qualified patient's qualifying medical condition.

2. A qualified physician must provide the qualified patient's records upon the request of the department.

3. The department shall approve or disapprove the request within 14 days after receipt of the complete documentation required by this paragraph. The request is ~~shall be~~ deemed approved if the department fails to act within this time period.

(g) A qualified physician must evaluate an existing

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qualified patient at least once every 52 ~~30~~ weeks before issuing a new physician certification. A qualified physician who has issued a certification to the patient after conducting an in-person physical examination as defined in subparagraph (a)1. may conduct the evaluation through telehealth as defined in s. 456.47. A physician must:

1. Determine whether ~~if~~ the patient still meets the requirements to be issued a physician certification under paragraph (a).

2. Identify and document in the qualified patient's medical records whether the qualified patient experienced either of the following related to the medical use of marijuana:

a. An adverse drug interaction with any prescription or nonprescription medication; or

b. A reduction in the use of, or dependence on, other types of controlled substances as defined in s. 893.02.

3. Submit a report with the findings required pursuant to subparagraph 2. to the department. The department shall submit such reports to the Consortium for Medical Marijuana Clinical Outcomes Research established pursuant to s. 1004.4351.

(7) IDENTIFICATION CARDS.—

(d) Applications for identification cards must be submitted on a form prescribed by the department. The department may charge a reasonable fee associated with the issuance, replacement, and renewal of identification cards. The fee for any veteran who was honorably discharged from the United States Armed Forces may not exceed $15. The department shall allocate $10 of the identification card fee to the Division of Research at Florida Agricultural and Mechanical University for the

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purpose of educating minorities about marijuana for medical use and the impact of the unlawful use of marijuana on minority communities. The department shall contract with a third-party vendor to issue identification cards. The vendor selected by the department must have experience performing similar functions for other state agencies.

Section 2. 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 medical marijuana; amending s. 381.986, F.S.; increasing the number of supply limits of marijuana which a qualified physician may issue in a single physician certification for the medical use of marijuana; revising the frequency with which qualified physicians must evaluate existing qualified patients for a physician certification for the medical use of marijuana; providing that the fee associated with identification cards for certain veterans of the United States Armed Forces may not exceed a specified amount; providing an effective date.

By Senator Calatayud

38-00755A-26 20261032__

A bill to be entitled

An act relating to medical marijuana; amending s. 381.986, F.S.; increasing the number of supply limits of marijuana which a qualified physician may issue in a single physician certification for the medical use of marijuana; revising the frequency with which qualified physicians must evaluate existing qualified patients for a physician certification for the medical use of marijuana; revising the frequency with which qualified patient and caregiver identification cards must be renewed, from annually to biennially; requiring the Department of Health to waive all fees associated with identification cards for certain veterans of the United States Armed Forces; providing an effective date.

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

Section 1. Paragraphs (f) and (g) of subsection (4) and paragraphs (a) and (d) of subsection (7) of section 381.986, Florida Statutes, are amended to read:

381.986 Medical use of marijuana.—

(4) PHYSICIAN CERTIFICATION.—

(f) A qualified physician may not issue a physician certification for more than ten ~~three~~ 70-day supply limits of marijuana or more than twenty ~~six~~ 35-day supply limits of marijuana in a form for smoking. The department shall quantify by rule a daily dose amount with equivalent dose amounts for each allowable form of marijuana dispensed by a medical

marijuana treatment center. The department shall use the daily dose amount to calculate a 70-day supply.

1. A qualified physician may request an exception to the daily dose amount limit, the 35-day supply limit of marijuana in a form for smoking, and the 4-ounce possession limit of marijuana in a form for smoking established in paragraph (14)(a). The request must ~~shall~~ be made electronically on a form adopted by the department in rule and must include, at a minimum:

a. The qualified patient's qualifying medical condition.

b. The dosage and route of administration that was insufficient to provide relief to the qualified patient.

c. A description of how the patient will benefit from an increased amount.

d. The minimum daily dose amount of marijuana that would be sufficient for the treatment of the qualified patient's qualifying medical condition.

2. A qualified physician must provide the qualified patient's records upon the request of the department.

3. The department shall approve or disapprove the request within 14 days after receipt of the complete documentation required by this paragraph. The request is ~~shall be~~ deemed approved if the department fails to act within this time period.

(g) A qualified physician must evaluate an existing qualified patient at least once every 104 ~~30~~ weeks before issuing a new physician certification. A qualified physician who has issued a certification to the patient after conducting an in-person physical examination as defined in subparagraph (a)1. may conduct the evaluation through telehealth as defined in s.

456.47. A physician must:

1. Determine whether ~~if~~ the patient still meets the requirements to be issued a physician certification under paragraph (a).

2. Identify and document in the qualified patient's medical records whether the qualified patient experienced either of the following related to the medical use of marijuana:

a. An adverse drug interaction with any prescription or nonprescription medication; or

b. A reduction in the use of, or dependence on, other types of controlled substances as defined in s. 893.02.

3. Submit a report with the findings required pursuant to subparagraph 2. to the department. The department shall submit such reports to the Consortium for Medical Marijuana Clinical Outcomes Research established pursuant to s. 1004.4351.

(7) IDENTIFICATION CARDS.—

(a) The department shall issue medical marijuana use registry identification cards for qualified patients and caregivers who are residents of this state, which must be renewed biennially ~~annually~~. The identification cards must be resistant to counterfeiting and tampering and must include, at a minimum, the following:

1. The name, address, and date of birth of the qualified patient or caregiver.

2. A full-face, passport-type, color photograph of the qualified patient or caregiver taken within the 90 days immediately preceding registration or the Florida driver license or Florida identification card photograph of the qualified patient or caregiver obtained directly from the Department of

Highway Safety and Motor Vehicles.

3. Identification as a qualified patient or a caregiver.

4. The unique numeric identifier used for the qualified patient in the medical marijuana use registry.

5. For a caregiver, the name and unique numeric identifier of the caregiver and the qualified patient or patients that the caregiver is assisting.

6. The expiration date of the identification card.

(d) Applications for identification cards must be submitted on a form prescribed by the department. The department may charge a reasonable fee associated with the issuance, replacement, and renewal of identification cards. However, the department shall waive all such fees for any veteran who was honorably discharged from the United States Armed Forces. The department shall allocate $10 of the identification card fee to the Division of Research at Florida Agricultural and Mechanical University for the purpose of educating minorities about marijuana for medical use and the impact of the unlawful use of marijuana on minority communities. The department shall contract with a third-party vendor to issue identification cards. The vendor selected by the department must have experience performing similar functions for other state agencies.

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

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 1684
INTRODUCER:	Senator Calatayud
SUBJECT:	Parkinson's Disease Registry
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1684 amends s. 1004.4352, F.S., to require the Department of Health (DOH), subject to a specific appropriation, to contract with the Consortium for Parkinson's Disease Research, housed at the University of South Florida (USF) under the Parkinson's Disease Research Act of 2025, for the establishment and maintenance of a Parkinson's Disease Registry to ensure that the Parkinson's disease data submitted by physicians for inclusion in the registry is maintained and available for research to advance therapies, improve patient outcomes, and find potential cures for Parkinson's disease.

The bill also requires that, beginning January 1, 2027, each allopathic or osteopathic physician licensed in Florida who diagnoses or treats a patient with Parkinson's disease must report to the registry information specified under DOH rule which indicates patient demographics, diagnosis, stage of disease, medical history, laboratory data, the methods of diagnosis or treatment, and any other information the Parkinson's Disease Research Board recommends for inclusion in the registry. The bill creates disclosure requirements pertaining to the registry and the ability for patients to opt-out of having their personal identifying information included in the registry.[1]

The bill creates reporting requirements relating to the registry and provides physicians with immunity from certain liabilities for having submitted information to the registry as required by the bill.

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

[1] SB 1684 is linked to SB 1686. The latter bill provides that all records and personal identifying information of persons diagnosed with or treated for Parkinson's disease which is submitted to the registry under SB 1684 are confidential and exempt from public records requirements.

II. Present Situation:

Parkinson's Disease

Parkinson's disease is a movement disorder of the nervous system[2] that worsens over time. Although Parkinson's disease cannot be cured, medications may help control and improve symptoms.[3]

Parkinson's disease is very common overall, ranking second among age-related degenerative brain diseases. It is also the most common motor (movement-related) brain disease. Experts estimate that it affects at least one percent of people over the age of 60 worldwide.[4]

Parkinson's disease is not fatal, but the symptoms and effects are often contributing factors to death. The average life expectancy for Parkinson's disease in 1967 was a little under 10 years after a patient's diagnosis. Since then, that expectancy has increased by about 55 percent, rising to more than 14.5 years. That, combined with the fact that Parkinson's diagnosis is much more likely after age 60, means this condition does not often affect the life expectancy by more than a few years.[5]

Parkinson's Disease Symptoms & Complications

Parkinson's disease symptoms can be different for everyone. Early symptoms may be mild and may go unnoticed. Symptoms often begin on one side of the body, then affect both sides as the disease progresses. Symptoms are usually worse on one side than the other.[6]

Parkinson's disease symptoms may include:[7]

- Tremors – Rhythmic shaking that usually begins in the hands or fingers. Sometimes a tremor begins in the foot or jaw, or an individual may rub their thumb and forefinger back and forth, also known as a pill-rolling tremor. The hand may tremble when at rest or when under stress. Some individuals notice less shaking when doing some sort of task or moving around.
- Bradykinesia (slow movement) – Parkinson's disease may slow movement, making simple tasks more difficult. It can be challenging to get out of a chair, shower, or get dressed. The disease may cause less facial expression and make it difficult to blink.
- Rigid muscles – Parkinson's disease can cause stiff muscles in any part of the body. Muscles may feel tense and painful, and arm movements may become short and jerky.

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[2] The nervous system is a network of nerve cells that controls many parts of the body, including movement. *See* Mayo Clinic, *Parkinson's Disease, available at* https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055#:~:text=Parkinson's%20disease%20is%20a%20movement,a%20foot%20or%20the%20jaw. (last visited Feb. 6, 2026).

[3] Mayo Clinic, *Parkinson's Disease, available at* https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055#:~:text=Parkinson's%20disease%20is%20a%20movement,a%20foot%20or%20the%20jaw. (last visited Feb. 6, 2026).

[4] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

[5] *Id*.

[6] *Supra* note 2.

[7] *Id*.

- Poor posture and balance – Parkinson's disease may cause posture to become stooped, and an individual may experience falls or problems with balance.
- Loss of automatic movements – Parkinson's disease may lessen an individual's ability to make certain movements that typically are accomplished without thinking, including blinking, smiling, or swinging arms while walking.
- Speech changes – The disease may result in soft or quick speech, slurring, or hesitation prior to speaking. Speech may become flat or monotone, without typical speech patterns.
- Writing changes – Trouble writing and writing that appears cramped and small are a sign of the disease.
- Nonmotor symptoms – These may include depression; anxiety; constipation; sleep problems, including acting out dreams; the need to urinate often; trouble smelling; problems thinking and with memory; feeling very tired; blood pressure changes; and pain or cramps in muscles and joints.

Individuals with Parkinson's disease may have treatable complications, including:[8]

- Trouble thinking clearly – Parkinson's disease can affect memory, language, and reasoning skills. The disease can also lead to dementia or other conditions that affect thinking. These complications usually occur later in the disease's progression, and typically medications have only a modest benefit in managing symptoms.
- Emotional changes and depression – Some people feel irritable and concerned early in the course of Parkinson's disease, experiencing depression and anxiety. Medications and other treatments can assist with these changes.
- Trouble swallowing and chewing – Late-stage Parkinson's disease affects the muscles in the mouth causing trouble swallowing and chewing, which can lead to a nutrient deficiency. The collection of food or saliva in the mouth can also pose a choking hazard or cause drooling.
- Sleep problems and sleep disorders – Individuals with Parkinson's disease may wake often during the night, have nightmares, and fall asleep during the day.
- Rapid eye movement sleep behavior disorder – This involves acting out dreams, and medications and other therapies may help improve sleep.

Causes of Parkinson's Disease

Parkinson's disease causes a specific area of the brain, the basal ganglia,[9] to deteriorate. As this area deteriorates, the ability to control the areas regulated by this portion of the brain decreases. Researchers have uncovered that Parkinson's disease causes a major shift in brain chemistry.[10]

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[8] Mayo Clinic, *Parkinson's Disease, available at* https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055#:~:text=Parkinson's%20disease%20is%20a%20movement,a%20foot%20or%20the%20jaw. (last visited Feb. 6, 2026).

[9] The basal ganglia are a cluster of nuclei found deep to the neocortex of the brain. It has a multitude of functions associated with reward and cognition but is primarily involved in motor control. In particular, the basal ganglia are considered to be a gate-keeping mechanism for the initiation of motor movement, effectively choosing which actions to allow and which actions to inhibit. See National Institutes of Health, National Library of Medicine, National Center for Biotechnology Information, *Neuroanatomy, Basal Ganglia, available at* *https://www.ncbi.nlm.nih.gov/books/NBK537141/#:~:text=The%20basal%20ganglia%20is%20a,primarily%20involved%20in%20motor%20control.* (last visited Feb. 6, 2026).

[10] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

Under normal circumstances, the brain uses chemicals known as neurotransmitters to control how brain cells (neurons) communicate with each other. With Parkinson's disease, an individual does not have enough dopamine, one of the most important neurotransmitters.[11]

When the brain sends activation signals telling the muscles to move, it fine-tunes the movements using cells that require dopamine. A lack of dopamine causes slowed movements and tremors, symptoms of Parkinson's disease.[12]

As Parkinson's disease progresses, the symptoms expand and intensify. Later stages of the disease often affect brain functions, causing dementia-like symptoms and depression.[13]

The cause of Parkinson's disease is unknown, but several factors seem to play a role, including:[14]

- Genes – Specific genetic changes are linked to Parkinson's disease, but these are rare unless many family members have been diagnosed with the disease.
- Environmental factors – Exposure to certain toxins or other environmental factors may increase the risk of later Parkinson's disease.

Many changes occur in the brains of individuals with Parkinson's disease. Researchers are studying the changes which include:[15]

- The presence of Lewy bodies – Clumps of proteins in the brain, called Lewy bodies, are associated with Parkinson's disease and researchers believe these proteins hold an important clue to the cause of the disease.
- Alpha-synuclein found within Lewy bodies – Alpha-synuclein is a protein found in all Lewy bodies. It occurs in a clumped form that cells cannot break down. This is currently an important focus among Parkinson's disease researchers. Alpha-synuclein has been found in the spinal fluid of individuals who later have Parkinson's disease.
- Altered mitochondria – Mitochondria are powerhouse compartments inside cells that create most of the body's energy. Changes to mitochondria can cause cell damage and are often observed in the brains of individuals with Parkinson's disease.

Parkinson's Disease Risk Factors

Risk factors for Parkinson's disease include:[16]

- Age – The risk of Parkinson's disease increases with age. Usually, it starts around age 50 or older. The average age of onset is around age 70. Parkinson's disease can occur in younger adults, but it is rare. When individuals younger than age 50 are diagnosed with the disease, it is known as early-onset Parkinson's disease.

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[11] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).
[12] *Id*.
[13] *Id*.
[14] Mayo Clinic, *Parkinson's Disease, available at* https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055#:~:text=Parkinson's%20disease%20is%20a%20movement,a%20foot%20or%20the%20jaw. (last visited Feb. 6, 2026).
[15] *Id*.
[16] *Id*.

- Genetics – The risk of developing Parkinson's Disease increases if one or more first-degree relatives, such as parents or siblings, have been diagnosed with the disease. However, familial Parkinson's disease is only attributed to about 10 percent of all cases.[17]
- Sex – Men are more likely to develop Parkinson's disease than women.
- Exposure to toxins – Ongoing exposure to herbicides and pesticides may slightly increase the risk of developing Parkinson's disease.

Parkinson's Disease Prevention

Since the cause of Parkinson's disease is unknown, there are no proven ways to prevent it. However, research shows that some factors may help protect against it, including:[18]

- Exercise – Aerobic exercise has been linked to a lower risk of Parkinson's disease.
- Caffeine – Some studies show a link between drinking caffeinated beverages, such as coffee and green tea, may lower the risk of developing Parkinson's disease.
- Medicines – Some medications, such as ibuprofen and statins,[19] have been linked to a lower risk of the disease.

Parkinson's Disease Diagnosis and Tests

A biomarker is a biological molecule found in blood, other body fluids, or tissues that are a sign of a normal or abnormal process, or of a condition or disease. A biomarker may be used to see how well the body responds to a treatment for a disease or condition.[20]

Biomarker testing is a method to look for genes, proteins, and other substances (biomarkers or tumor markers) that can provide information about cancer and other conditions. Biomarkers are substances in the body that can give researchers and doctors information about a person's health. For example, high cholesterol is a biomarker of heart disease. Currently, the use of biomarkers is in the beginning stages to help diagnose Parkinson's disease.[21]

Diagnosing Parkinson's disease is mostly a clinical process, meaning it relies heavily on a health care provider examining the symptoms, asking questions, and reviewing medical history. Some diagnostic and lab tests are possible, but these are usually needed to rule out other conditions or certain causes; however, most lab tests are not necessary unless the patient is unresponsive to treatment for Parkinson's disease, which can indicate another condition.[22]

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[17] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).
[18] *Id*.
[19] Statins are drugs that can lower cholesterol. *See* Mayo Clinic, *Statins: Are these cholesterol-lowering drugs right for you?, available at* https://www.mayoclinic.org/diseases-conditions/high-blood-cholesterol/in-depth/statins/art-20045772#:~:text=Statins%20are%20drugs%20that%20can,of%20heart%20disease%20and%20stroke. (last visited Feb. 6, 2026).
[20] National Institutes of Health, National Cancer Institute, *Biomarker Testing for Cancer Treatment, available at* https://www.cancer.gov/about-cancer/treatment/types/biomarker-testing-cancer-treatment (last visited Feb. 6, 2026).
[21] Parkinson's Foundation, *Parkinson's Biomarkers, available at* https://www.parkinson.org/understanding-parkinsons/getting-diagnosed/biomarkers (last visited Feb. 6, 2026).
[22] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

When health care providers suspect Parkinson's disease or need to rule out other conditions, various imaging and diagnostic tests are possible, including:[23]

- Blood tests;
- Computed tomography (CT) scans;[24]
- Genetic testing;
- Magnetic resonance imaging (MRI);[25] and
- Positron emission tomography (PET) scans.[26]

Researchers have found ways to test for possible indicators of Parkinson's disease. Both of these tests involve the alpha-synuclein protein; however, these tests only serve to provide information that can help a provider in making a diagnosis.[27]

- Spinal tap – Looks for misfolded alpha-synuclein proteins in cerebrospinal fluid, which is the fluid that surrounds the brain and spinal cord. This test involves a spinal tap (lumbar puncture), where a health care provider inserts a needle into the spinal canal to collect cerebrospinal fluid for testing.
- Skin biopsy – Another possible test involving a biopsy of surface nerve tissue. A biopsy includes collecting a small sample of the skin, including the nerves in the skin. The samples come from a spot on the back and two spots on the leg. Analyzing the samples can help determine if the alpha-synuclein protein has a certain kind of malfunction that could increase the risk of developing Parkinson's disease.

Parkinson's Disease Management and Treatment

For now, Parkinson's disease is not curable, but there are multiple ways to manage its symptoms. The treatments can also vary from person to person, depending on the specific symptoms and how well certain treatments work. Medications are the primary way to treat this condition.[28]

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[23] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

[24] A CT scan is a type of imaging that uses X-ray techniques to create detailed images of the body. It then uses a computer to create cross-sectional images, also called slices, of the bones, blood vessels, and soft tissues inside the body. CT scan images show more detail than plain X-rays do. *See* Mayo Clinic, *CT Scan, available at* https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675 (last visited Feb. 6, 2026).

[25] An MRI is a noninvasive medical imaging test that produces detailed images of almost every internal structure in the human body, including the organs, bones, muscles, and blood vessels. MRI scanners create images of the body using a large magnet and radio waves. No ionizing radiation is produced during an MRI exam, unlike X-rays. These images give a physician important information in diagnosing a medical condition and planning a course of treatment. *See* Johns Hopkins Medicine, *Magnetic Resonance Imaging (MRI), available at* https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/magnetic-resonance-imaging-mri#:~:text=Magnetic%20resonance%20imaging%2C%20or%20MRI,large%20magnet%20and%20radio%20waves. (last visited Feb. 6, 2026).

[26] A PET scan is an imaging test that can help reveal the metabolic or biochemical function of tissues and organs. The PET scan uses a radioactive drug called a tracer to show both typical and atypical metabolic activity. A PET scan can often detect the atypical metabolism of the tracer in diseases before the disease shows up on other imaging tests, such as a CT and an MRI. *See* Mayo Clinic, *Positron emission tomography scan, available at* https://www.mayoclinic.org/tests-procedures/pet-scan/about/pac-20385078 (last visited Feb. 6, 2026).

[27] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

[28] Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

A secondary treatment option is surgery to implant a device that will deliver a mild electrical current to part of the brain (deep brain stimulation).[29] There are also experimental options, such as stem cell-based treatments, however, availability often varies, and many are not an option for individuals with Parkinson's disease.[30]

Medications that do one or more of the following are used to treat Parkinson's disease:[31]

- Adding dopamine – Medications like levodopa[32] can increase the available levels of dopamine in the brain. This medication is almost always effective, and when it does not work, that is usually a sign of some other form of parkinsonism[33] rather than Parkinson's disease. Long-term use of levodopa eventually leads to side effects that make it less effective.
- Simulating dopamine – Dopamine agonists are medications that have a dopamine-like effect. Dopamine is a neurotransmitter, causing cells to act in a certain way when a dopamine molecule latches onto them. Dopamine agonists can latch on and cause cells to behave the same way. These are more common in younger patients to delay starting levodopa.
- Dopamine metabolism blockers – The body has natural processes to break down neurotransmitters like dopamine. Medications that block the body from breaking down dopamine allow more dopamine to remain available to the brain. These medications are especially useful early on and can also help when combined with levodopa in later stages of Parkinson's disease.
- Levodopa metabolism inhibitors – These medications slow down how the body processes levodopa, helping it last longer. These medications may need careful use as they can have toxic effects and damage the liver. They are most often used to help as levodopa becomes less effective.
- Adenosine blockers – Medications that block how certain cells use adenosine (a molecule used in various forms throughout the body) can have a supportive effect when used alongside levodopa.

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[29] In years past, surgery was an option to intentionally damage and scar a part of the brain that was malfunctioning because of Parkinson's disease. Today, that same effect is possible using deep-brain stimulation, which uses an implanted device to deliver a mild electrical current to those same areas. The major advantage is that deep-brain stimulation is reversible, while intentional scarring damage is not. This treatment approach is almost always an option in later stages of Parkinson's disease when levodopa therapy becomes less effective, and in people who have a tremor that does not seem to respond to the usual medications. *See* Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

[30] Stem cell transplants add new dopamine-using neurons into the brain to take over for damaged ones. Neuron-repair treatments try to repair damaged neurons and encourage new neurons to form. Gene therapies and gene-targeted treatments target specific mutations that cause Parkinson's disease. Some also boost the effectiveness of levodopa or other treatments. *See* Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

[31] *Supra* note 27.

[32] Levodopa is the precursor to dopamine. Most commonly, clinicians use levodopa as a dopamine replacement agent for the treatment of Parkinson's disease. It is most effectively used to control bradykinetic symptoms apparent in Parkinson's disease. Levodopa is typically prescribed to a patient with Parkinson's disease once symptoms become more difficult to control with other anti-parkinsonism drugs. See National Institutes of Health, National Library of Medicine, National Center for Biotechnology Information, *Levodopa (L-Dopa), available at* https://www.ncbi.nlm.nih.gov/books/NBK482140/#:~:text=Levodopa%20is%20the%20precursor%20to,symptoms%20apparent%20in%20Parkinson%20disease. (last visited Feb. 6, 2026).

[33] "Parkinsonism" is an umbrella term that describes Parkinson's disease and conditions with similar symptoms. It can refer not only to Parkinson's disease but also to other conditions like multiple system atrophy or corticobasal degeneration. *See* Cleveland Clinic, *Parkinson's Disease, available at* https://my.clevelandclinic.org/health/diseases/8525-parkinsons-disease-an-overview#symptoms-and-causes (last visited Feb. 6, 2026).

- Other medications are used to treat specific symptoms of Parkinson's disease.

Parkinson's Disease Research in Florida

The Parkinson's Foundation designates the nation's top medical centers with specialized teams focused on Parkinson's disease clinical research and care as "Centers of Excellence."[34] Florida is home to three Parkinson's disease Centers of Excellence, including the Parkinson's Disease & Movement Disorders Center[35] at USF, the University of Florida's Movement Disorders and Neurorestoration Program,[36, 37] and the University of Miami's Miller School of Medicine.[38] Comparatively, California is home to five Centers of Excellence, New York is home to four, and Texas is home to one.[39]

Parkinson's Disease Research Act

In 2025, the Legislature enacted CS/CS/HB 1545, Engrossed 1,[40] which may be cited as the Parkinson's Disease Research Act (the Act), thereby creating s. 1004.4353, F.S., in the Early Learning-20 Education Code, to establish within USF the Florida Institute for Parkinson's Disease (Institute) as a statewide resource for Parkinson's disease research and clinical care. The purpose of the Institute is to find a cure for Parkinson's disease and to improve the quality of life and health outcomes for those affected by Parkinson's disease by advancing knowledge, diagnosis, and treatment of Parkinson's disease through research, clinical care, education, and advocacy.

The Act also created s. 1004.4352, F.S., to establish the Consortium for Parkinson's Disease Research (Consortium) within USF to consist of public and private universities and academic medical centers.[41] The purpose of the Consortium is to conduct rigorous scientific research and disseminate such research. The Parkinson's Disease Research Board (Board) was also created under the Act to direct the operations of the Consortium.

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[34] Parkinson's Foundation, *Global Care Network, available at* https://www.parkinson.org/living-with-parkinsons/finding-care/global-care-network (last visited Feb. 6, 2026).

[35] The USF's Parkinson's Disease & Movement Disorders Center is the only center in Florida primarily focused on Parkinson's disease research and treatment. The center currently offers multiple clinical trials to improve symptoms of early untreated Parkinson's disease, test innovative treatments, and study the disease's causes and progression. *See* USF Health, *Parkinson's Disease & Movement Disorders Center, available at* https://health.usf.edu/care/neurology/services-specialties/parkinsons (last visited Feb. 6, 2026).

[36] The University of Florida's (UF's) Movement Disorders and Neurorestoration Program operates within the UF's Norman Fixel Institute for Neurological Diseases and studies a variety of neurological disorders, including amyotrophic later sclerosis (ALS), dementia, Alzheimer's disease, and Parkinson's disease. See UFHealth, *About, available at* https://movementdisorders.ufhealth.org/about/ (last visited Feb. 6, 2026).

[37] The Program's Parkinson's disease research focuses on cognitive behavior and emotion, speech production, breathing and swallowing dysfunction, and development of deep brain stimulation. *See* UFHealth, *Clinical Research, available at* https://movementdisorders.ufhealth.org/research/clinical-research/ (last visited Apr. 3, 2025).

[38] Parkinson's Foundation, *Florida Chapter, available at* https://www.parkinson.org/florida/florida-chapter#florida-chapter (last visited Feb. 6, 2026).

[39] Parkinson's Foundation, *Global Care Network, available at* https://www.parkinson.org/living-with-parkinsons/finding-care/global-care-network (last visited Feb. 6, 2026).

[40] Chapter 2025-188, Laws of Florida.

[41] USF has housed the Consortium at the USF Morsani College of Medicine, according to the "inaugural" report, dated Oct. 15, 2025, submitted as required by s. 1004.4352(4)(e), F.S. (On file with the Senate Committee on Health Policy.)

The Act requires the Board to be composed of members representing each participating university or academic medical center,[42] appointed by the president or chief executive officer of each participant. Board members must have experience in a variety of scientific fields, including, but not limited to, neurology, psychology, nutrition, and genetics. Members are to be appointed to four-year terms and may be reappointed to serve additional terms. The Board chair is to be elected by the Board from among its members to serve a two-year term. The Board must meet at least semiannually at the call of the chair or, in his or her absence or incapacity, the vice chair.[43] Four members constitute a quorum. A majority vote of the members present is required for all actions of the Board. The Board may prescribe, amend, or repeal a charter governing the manner in which it conducts its business. A Board member serves without compensation but is entitled to receive reimbursement for travel expenses by the Consortium or the organization he or she represents.

The Act requires the Consortium to be administered by a director, appointed by and to serve at the pleasure of the Board. The director must, subject to the approval of the Board:

- Propose a budget for the Consortium.
- Foster the collaboration of scientists, researchers, and other appropriate personnel in accordance with the Consortium's charter.
- Engage individuals in public and private university and academic medical center programs relevant to the Consortium's work to participate in the Consortium.
- Identify and prioritize the research to be conducted by the Consortium.
- Prepare a plan for Parkinson's disease research for submission to the Board.
- Apply for grants to obtain funding for research conducted by the Consortium.
- Perform other duties as determined by the Board.

The Act requires the Board to adopt the plan for Parkinson's disease research annually and to award funds to members of the Consortium to perform research consistent with the plan. The Board must issue a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on research projects, research findings, community outreach initiatives, and future plans for the Consortium by October 15 of each year.

Implementation of the Act's provisions relating to the Consortium and the Board is subject to legislative appropriation for such purpose contained in the annual General Appropriations Act (GAA). The GAA for the current state fiscal year did not include a specific appropriation for the Consortium or the Board.

[42] *Id.* The Oct. 15, 2025, report proposes that the Board be composed of representatives of the USF Morsani College of Medicine, the University of Miami's Miller School of Medicine, the University of Florida's College of Medicine, the Michael J. Fox Foundation for Parkinson's Research, the Parkinson's Foundation, and a patient/family member representative.

[43] *Id.* The Oct. 15, 2025, report indicates that the Consortium will hold an initial meeting in February or March 2026 to nominate Board members, review a proposed mission and vision, and gather input on the highest research priorities, and that the first meeting of the Board may be scheduled for the summer of 2026 to formalize a call for research proposals pending future appropriations.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 1004.4352, F.S., in the Early Learning-20 Education Code, to require the Department of Health (DOH), subject to a specific appropriation, to contract with the Consortium to establish and maintain a Parkinson's Disease Registry to ensure that the Parkinson's disease data submitted by physicians for inclusion in the registry (see below) is maintained and available for research to advance therapies, improve patient outcomes, and find potential cures for Parkinson's disease. The bill provides that the contract must require the Consortium to use a nationally recognized platform to collect data from physicians.

The bill also amends the Education Code to require that, beginning January 1, 2027, each allopathic physician licensed under ch. 458, F.S., or osteopathic physician licensed under ch. 459, F.S., who diagnoses or treats a patient with Parkinson's disease must report to the registry information, specified under DOH rule, which indicates patient demographics, diagnosis, stage of disease, medical history, laboratory data, the methods of diagnosis or treatment, and any other information the Board recommends for inclusion in the registry. The bill requires the DOH, when adopting such rules, to consult with the Board, the Board of Medicine, and the Board of Osteopathic Medicine.

The bill requires a physician who diagnoses a patient with Parkinson's disease to notify the patient, orally and in writing, about the registry and the required reporting. If a patient does not want his or her personal identifying data to be included in the registry, the physician must certify in writing that the patient has been notified about the registry, provided information about the operation of the registry, and afforded the opportunity to ask questions, but wishes to opt-out of the registry. If a patient opts-out, only deidentified personal health information relating to that patient may be submitted for inclusion in the registry.

The bill requires the Board to provide quarterly reports to the DOH on the data collected and requires the DOH, starting January 1, 2028, and annually thereafter, to submit a report to the Governor and the Legislature's presiding officers detailing the following:

- The incidence and prevalence of Parkinson's disease in this state, by county.
- Demographic information, including, but not limited to, patients' age, sex, and race.
- Any recommendations from the Board for legislative changes necessary for improving operation of the registry.

The bill requires the DOH to publish on its website information on Parkinson's disease, including ongoing research, available resources for persons diagnosed with Parkinson's disease, and the annual report described above.

The bill provides that a physician who, in good faith, complies with the bill's requirements is not liable for damages and may not be subject to disciplinary action solely for having submitted information to the registry as required by the bill.

Section 2 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:

The Florida Constitution provides that the Legislature creates the policies and laws of the state[44] and the executive branch executes the laws[45] and policies established by the Legislature. The Legislature is permitted to transfer subordinate functions "to permit administration of legislative policy *by an agency* with the expertise and flexibility to deal with complex and fluid conditions." (Emphasis added.)

However, the Legislature "may not delegate the power to enact a law or the right to exercise unrestricted discretion in applying the law."[46] The Florida Supreme Court has found that "statutes granting power to the executive branch 'must clearly announce adequate standards to guide ... in the execution of the powers delegated. The statute must so clearly define the power delegated that the [executive] is precluded from acting through whim, *showing favoritism, or exercising unbridled discretion*.' "[47] (Emphasis added.)

Under Florida's Administrative Procedure Act (APA), an agency must have both a general and a specific grant of rulemaking authority from the Legislature.[48] The general grant of rulemaking authority is usually broad, while the specific grant of rulemaking authority must provide specific standards and guidelines the agency must implement through rulemaking.[49] Additionally, administrative bodies or commissions, unless

[44] Article III, section 1 of the State Constitution vests the "legislative power of the state" in the Legislature. Legislative power is further explained by the courts in *O.M. v. Dep't of Children & Families*, 404 So. 3d 547, 552 (Fla. 3d DCA 2025); *Webb v. Hill*, 75 So. 2d 596, 605 (Fla. 1954); *State v. Barquet*, 262 So. 2d 431, 433 (Fla. 1972).
[45] The executive branch ensures that the "laws be faithfully executed, commission all officers of the state and counties, and transact all necessary business with the officers of government." FLA. CONST. art. IV, s. 4.
[46] *Bush v. Schiavo,* 885 So. 2d 321 (Fla. 2004).
[47] *Id.*
[48] Sections 120.52(8) and 120.536(1), F.S.
[49] *Sloban v. Florida Board of Pharmacy*, 982 So. 2d 26, 29-30 (Fla. 1st DCA 2008); *Board of Trustees of the Internal Improvement Trust Fund v. Day Cruise Association, Inc.*, 794 So. 2d 696, 704 (Fla. 1st DCA 2001).

specifically created in the Constitution, are creatures of statute and derive only the powers specified therein.[50].

SB 1684, on lines 52-62, directs certain licensed physicians to report to the Parkinson's Disease Registry information specified by DOH rule, and the rule is to include a list of items. The final item in the list is "any other information [the Parkinson's Disease Research Board] recommends for inclusion in the registry."

Under that language, the bill may be interpreted to require the DOH to adopt a rule requiring affected physicians to report any data that the Parkinson's Disease Research Board decides to recommend. Such a provision could be viewed as violating the State Constitution's requirement that a statute must so clearly define the power delegated to an Executive Branch agency that the agency is precluded from acting through whim, showing favoritism, or exercising unbridled discretion.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None identified.

B. Private Sector Impact:

SB 1684 provides for the creation and maintenance of the Parkinson's Disease Registry if the Legislature provides an appropriation for that purpose. If such funds are appropriated:

- The bill's requirement for certain licensed physicians to report information to the registry could create some level of cost for those physicians since they will have to devote their time or their staff's time to fulfilling that required duty.
- The Consortium for Parkinson's Disease Research, through its contract with the DOH that is required under the bill, may incur costs associated with creating and maintaining the registry.

C. Government Sector Impact:

If funding is appropriated and the Parkinson's Disease Registry is created and implemented, the DOH, through its contract with the Consortium that is required under the bill, may incur costs associated with creating and maintaining the registry. The DOH has not provided an estimate of the bill's operational or fiscal impact on the department, as of this writing.

VI. Technical Deficiencies:

None.

[50] *Grove Isle, Ltd. v. State Dept of Environmental Regulation*, 454 So. 2d 571 (Fla. 1st DCA 1984). *See also*, *WHS Trucking LLC v. Reemployment Assistance Appeals Comm'n*, 183 So. 3d 460 (Fla. 1st DCA 2016).

VII. Related Issues:

The bill creates several statutory requirements for allopathic and osteopathic physicians, as well as liability protections for those physicians, within the Early Learning-20 Education Code. Such provisions relating to health care practitioners are typically housed within the practitioners' respective practice acts.

VIII. Statutes Affected:

This bill substantially amends section 1004.4352 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 Calatayud

38-01287-26 20261684__

A bill to be entitled

An act relating to the Parkinson's Disease Registry; amending s. 1004.4352, F.S.; defining the term "department"; subject to a specific appropriation, requiring the Department of Health to contract with the Consortium for Parkinson's Disease Research within the University of South Florida for a specified purpose; requiring the department contract with the consortium to require use of a nationally recognized platform to collect data for the registry; beginning on a specified date, requiring physicians who diagnose or treat a patient with Parkinson's disease to report specified information to the registry; requiring the department to adopt certain rules in consultation with the Parkinson's Disease Research Board, the Board of Medicine, and the Board of Osteopathic Medicine; requiring physicians to notify patients orally and in writing of specified information before submitting reports to the registry; providing procedures for a patient to opt out of the registry; requiring the Parkinson's Disease Research Board to submit quarterly reports to the department; requiring the department to submit annual reports to the Governor and the Legislature; providing requirements for the reports; requiring the department to publish certain information and the annual reports on its website; providing physicians immunity from liability and disciplinary action under certain circumstances; providing an effective date.

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

Section 1. Subsection (3) of section 1004.4352, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

1004.4352 Parkinson's disease research.—

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

(a) "Board" means the Parkinson's Disease Research Board.

(b) "Consortium" means the Consortium for Parkinson's Disease Research.

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

(5) PARKINSON'S DISEASE REGISTRY.—Subject to a specific appropriation, the department shall contract with the consortium to establish and maintain a Parkinson's Disease Registry to ensure that the Parkinson's disease data required to be submitted under paragraph (a) is maintained and available for use for research to advance therapies, improve patient outcomes, and find potential cures for the disease. The department contract must require the consortium to use a nationally recognized platform to collect data from physicians as required in paragraph (a).

(a) Beginning January 1, 2027, each physician licensed under chapter 458 or chapter 459 who diagnoses or treats a patient with Parkinson's disease shall report to the registry information specified by the department, by rule, which indicates patient demographics, diagnosis, stage of disease, medical history, any laboratory data, the methods of diagnosis or treatment used, and any other information the board

recommends for inclusion in the registry. In adopting rules under this paragraph, the department shall consult with the board, the Board of Medicine, and the Board of Osteopathic Medicine.

(b) A physician who diagnoses a patient with Parkinson's disease shall notify the patient orally and in writing about the registry and the required reporting under this subsection. If a patient does not want his or her personal identifying information included in the registry, the physician must certify in writing that the patient has been notified of the registry, provided information about the operation of the registry, and afforded the opportunity to ask questions, but wishes to opt out of the registry. If a patient opts out of the registry, only deidentified personal health information may be submitted for inclusion in the registry.

(c) The board shall provide quarterly reports to the department on the data collected. By January 1, 2028, and annually thereafter, the department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives detailing all of the following:

1. The incidence and prevalence of Parkinson's disease in this state, by county.

2. Demographic information, including, but not limited to, patients' age, sex, and race.

3. Any recommendations from the board for legislative changes necessary for improving operation of the registry.

(d) The department shall publish on its website information on Parkinson's disease, including ongoing research, available resources for persons diagnosed with Parkinson's disease, and

the annual report prepared under paragraph (c).

(e) A physician who in good faith complies with the requirements of this subsection is not liable for damages and may not be subject to disciplinary action for the sole reason of having submitted information to the registry as required under paragraph (a).

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

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 1686
INTRODUCER:	Senator Calatayud
SUBJECT:	Public Records/Parkinson's Disease Registry
DATE:	February 10, 2026 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1686 provides that all records and personal identifying information relating to persons diagnosed with or treated for Parkinson's disease which are submitted to the Parkinson's Disease Registry under statutory provisions to be created under SB 1684, are confidential and exempt from the public records requirements of s. 119.07(1), F.S., and s. 24(a), Article I of the State Constitution, with exceptions.

The bill provides legislative findings that the public records exemption it creates is a public necessity. The bill specifies that its provisions are subject to the Open Government Sunset Review Act in accordance with s. 119.15, F.S., and that such provisions shall stand repealed on Oct. 2, 2031, unless reviewed and saved from repeal through reenactment by the Legislature.

The bill provides that it takes effect on the same date that an unspecified Senate bill, or other similar legislation, takes effect if such legislation is adopted in the same legislative session or extension thereof.

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]

[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).

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.

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

[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."
[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).

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]

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:

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[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).

[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.

- 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 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]

Parkinson's Disease Research Act

In 2025, the Legislature enacted CS/CS/HB 1545, Engrossed 1,[27] which may be cited as the Parkinson's Disease Research Act, thereby creating s. 1004.4353, F.S., to establish within the University of South Florida (USF) the Florida Institute for Parkinson's Disease (Institute) as a statewide resource for Parkinson's disease research and clinical care. The purpose of the Institute is to find a cure for Parkinson's disease and to improve the quality of life and health outcomes for those affected by Parkinson's disease by advancing knowledge, diagnosis, and treatment of Parkinson's disease through research, clinical care, education, and advocacy.

The 2025 law also created s. 1004.4352, F.S., to establish the Consortium for Parkinson's Disease Research (Consortium) within USF to consist of public and private universities and academic medical centers. The purpose of the Consortium is to conduct rigorous scientific research and disseminate such research.

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[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.
[26] Section 119.15(7), F.S.
[27] Chapter 2025-188, Laws of Florida.

SB 1684, if enacted, will amend s. 1004.4352, F.S., to require the Department of Health (DOH), subject to a specific appropriation, to contract with the Consortium to establish and maintain a Parkinson's Disease Registry to ensure that the Parkinson's disease data submitted for inclusion in the registry is maintained and available for research to advance therapies, improve patient outcomes, and find potential cures for Parkinson's disease.

See the staff analysis of SB 1684 for more details about the Parkinson's Disease Research Act and the proposed Parkinson's Disease Registry.

III. Effect of Proposed Changes:

SB 1686 provides that all records and personal identifying information relating to persons diagnosed with or treated for Parkinson's disease which are submitted to the Parkinson's Disease Registry under statutory provisions to be created under SB 1684, are confidential and exempt from the public records requirements of s. 119.07(1), F.S., and s. 24(a), Article I of the State Constitution, with the following exceptions:

- Release of such registry data may be made with the written consent of persons to whom the information applies.
- The DOH or the Consortium may contact individuals for the purpose of epidemiological investigation and monitoring, provided information that is confidential under the bill is not further disclosed.
- The DOH may enter into a data-sharing agreement with any other governmental agency or entity for the purpose of medical or scientific research, provided such governmental agency or entity does not further disclose information that is confidential under the bill.

The bill provides legislative findings that the public records exemption it creates is a public necessity. The bill specifies that its provisions are subject to the Open Government Sunset Review Act in accordance with s. 119.15, F.S., and that such provisions shall stand repealed on Oct. 2, 2031, unless reviewed and saved from repeal through reenactment by the Legislature.

The bill provides that it takes effect on the same date that an unspecified Senate bill, or other similar legislation, takes effect if such legislation is adopted in the same legislative session or extension thereof.

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 records and personal identifying information relating to persons diagnosed with or treated for Parkinson's disease which is submitted to the Parkinson's Disease Registry 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 the DOH and the Consortium are unable to effectively implement the legislative purpose of the Parkinson's Disease Registry without access to these records and information, which include personal medical information, the disclosure of which would violate federal patient privacy laws. The statement further provides a legislative finding that it is a public necessity to make such records and information held by the DOH confidential and exempt to protect the privacy rights of persons diagnosed with and treated for Parkinson's disease in this state and to promote the effective administration of the department's epidemiological research and tracking activities.

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 personal medical information, the disclosure of which would violate federal patient privacy laws. This bill exempts records and personal identifying information relating to persons diagnosed with or treated for Parkinson's disease which is submitted to the Parkinson's Disease Registry. The records exempted in the bill are narrowly tailored to the most relevant information for accomplishing the bill's stated goals. 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 may be subject to the cost associated with an agency's review and potential redactions of exempt records in response to a public records request.

C. Government Sector Impact:

The DOH has not provided an estimate of the bill's fiscal or operational impacts on the department, as of this writing.

VI. Technical Deficiencies:

SB 1686 provides that the bill takes effect on the same date that an unspecified Senate bill, or other similar legislation, takes effect if such legislation is adopted in the same legislative session or extension thereof. This bill should be amended to provide that it takes effect on the same date that SB 1684 takes effect.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 1004.4352 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.

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LEGISLATIVE ACTION

Senate . House

. . . . . .

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

Senate Amendment (with directory amendment)

Delete line 69
and insert:
SB 1684 or similar legislation takes effect, if such legislation

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:
Delete line 13
and insert:

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section 1004.4352, Florida Statutes, as created by SB 1684, 2026

By Senator Calatayud

38-01487-26 20261686__

A bill to be entitled

An act relating to public records; amending s. 1004.4352, F.S.; providing an exemption from public records requirements for certain records and personal identifying information submitted to the Parkinson's Disease Registry; 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. Paragraph (f) is added to subsection (5) of section 1004.4352, Florida Statutes, as created by SB __, 2026 Regular Session, to read:

1004.4352 Parkinson's disease research.—

(5) PARKINSON'S DISEASE REGISTRY.—Subject to a specific appropriation, the department shall contract with the consortium to establish and maintain a Parkinson's Disease Registry to ensure that the Parkinson's disease data required to be submitted under paragraph (a) is maintained and available for use for research to advance therapies, improve patient outcomes, and find potential cures for the disease. The department contract must require the consortium to use a nationally recognized platform to collect data from physicians as required in paragraph (a).

(f) All records and personal identifying information relating to persons diagnosed with or treated for Parkinson's disease which is submitted to the registry under this subsection are confidential and exempt from s. 119.07(1) and s. 24(a), Art.

I of the State Constitution, except that:

1. Release may be made with the written consent of persons to whom the information applies.

2. The department or the consortium may contact individuals for the purpose of epidemiological investigation and monitoring, provided information that is confidential under this subsection is not further disclosed.

3. The department may enter into a data-sharing agreement with any other governmental agency or entity for the purpose of medical or scientific research, provided such governmental agency or entity does not further disclose information that is confidential under this subsection.

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 all records and personal identifying information relating to persons diagnosed with or treated for Parkinson's disease which is submitted to the Parkinson's Disease Registry pursuant to s. 1004.4352(5), Florida Statutes, be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. The Department of Health and the University of South Florida's Consortium for Parkinson's Disease Research are unable to effectively implement the legislative purpose of the Parkinson's Disease Registry, created under s. s. 1004.4352(5), 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 persons diagnosed with and treated for Parkinson's disease 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 ___ 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

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 1760
INTRODUCER:	Senator Brodeur and others
SUBJECT:	Health Care Coverage
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rainer/Johnson	Brown	HP	**Pre-meeting**
2.			AP	

I. Summary:

SB 1760 amends numerous Florida Statutes relating to state oversight of health care insurance coverage, both in commercial health insurance and Medicaid.

The bill establishes the Joint Legislative Committee on Medicaid Oversight to ensure the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending. The bill creates a statutory definition for the term "Joint Legislative Committee on Medicaid Oversight" to specify a committee designated by joint rule of the Legislature, by the presiding officer of either house of the Legislature, or by agreement between the presiding officers.

The bill requires the committee to identify and recommend policies and authorizes the committee to submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

The bill also creates additional Medicaid managed care plan reporting requirements for purposes of capitation rate setting and disclosure of financial relationships with affiliated entities.

The bill requires that a contract between the Agency for Health Care Administration (AHCA) and a Medicaid managed care plan must require that any third party administrative entity contracted by the plan must adhere to all pertinent requirements of the Medicaid program placed on the plan under the plan's contract with the AHCA.

The bill revises the Medicaid achieved savings rebate (ASR) to alter the amount of profit that a managed care plan may retain versus how much of such profit must be shared with the state. Payments by a plan to affiliated entities in excess of market rates are excluded as an allowable expense under the bill when the AHCA calculates a plan's ASR.

The bill amends statutes relating to Medicaid managed care plan medical loss ratios (MLR) to correct a reference to federal regulations and to specify that MLRs must be calculated for each plan separately for each component of Statewide Medicaid Managed Care and in the aggregate. The AHCA must calculate such MLRs quarterly and annually and report to the Governor and the Legislature no later than six months after the end of each such period.

The bill amends the Insurance Code relating to the oversight of pharmacy benefit managers (PBMs), which are regulated by the Office of Insurance Regulation (OIR). The bill creates numerous prohibitions against PBM behavior relating to contracting with and reimbursing pharmacies and the inclusion or exclusion of pharmacies from PBM provider networks. The bill also prohibits a PBM from maintaining any ownership or investment interest in, or sharing common ownership with, an affiliated manufacturer, as that term is defined by the bill.

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

II. Present Situation:

Joint Legislative Committees

A joint legislative committee is composed of members of the Senate and the House of Representatives, appointed by their respective presiding officers, to oversee a specified legislative function. Joint legislative committees and other joint units of the Legislature are governed by joint rules of the Senate and the House. The joint rules are adopted in the organizational session for each legislative term.[1]

For the current legislative term (2024-2026), the joint rules provide for the following standing Joint Committees:

- Administrative Procedures Committee.
- Committee on Public Counsel Oversight.
- Legislative Auditing Committee.[2]

The current joint rules contain the governance and membership requirements for all Joint Committees.[3] Procedures,[4] powers,[5] and administration[6] for the Joint Committees are also set out. The joint also provide for special powers and duties for each standing Joint Committee.[7]

Legislative committees are also described in ch. 11, F.S. Any standing or select committees formed by the Legislature are not executive agencies.[8] The committees are entitled to all appropriations made by the Legislature.[9] Standing and select legislative committees are given

[1] Fla. Const. Art. III, § 3. For the current Legislative term of 2024-2026, the organizational session was held, in Nov. 2024, and concurrent resolution SRC 2 - Org was adopted as the Joint Rules.
[2] Joint Rule 4.1.
[3] Joint Rules 4.1(3) and (4).
[4] Joint Rule 4.2.
[5] Joint Rule 4.3.
[6] Joint Rule 4.4.
[7] Joint Rules 4.5 through 4.7.
[8] Section 11.135, F.S.
[9] *Id.*

testimony, subpoena, and document production powers.[10] All joint committees are ultimately governed by joint rules of Senate and House of Representatives.[11]

The Auditor General

Florida's Auditor General is a constitutional and legislative officer.
Article III, s. 2, of the Florida Constitution provides that "The legislature shall appoint an auditor to serve at its pleasure who shall audit public records and perform related duties as prescribed by law or concurrent resolution." As a certified public accountant, and the state's independent auditor, the auditor general is responsible for providing unbiased, timely, and relevant information that the Legislature, citizens of the state of Florida, public entity management, and other stakeholders can use to promote government accountability and stewardship, as well as improve government operations.[12] Chapter 11, F.S., establishes the general authority and duties of the auditor general.[13]

Medicaid Managed Care

Services under the Florida Medicaid program can either be provided under Statewide Medicaid Managed Care (SMMC) or the fee-for-service (FFS) delivery systems.[14] Health care services within SMMC are managed by contracted managed care plans. A Medicaid recipient generally must enroll in the SMMC and can choose a managed care plan available in his or her area of the state.[15] If a recipient is required to choose a plan but fails to, he or she is auto-assigned to one.

Certain recipients are not required to enroll in a managed care plan but may choose to. Such recipients are those receiving prescribed pediatric extended care (PPEC) services, recipients enrolled in the iBudget waiver or in an iBudget waiver pre-enrollment category,[16] recipients with non-Medicare credible coverage,[17] recipients in residential treatment facilities, and persons eligible for refugee assistance.[18] Other recipients are excluded from SMMC. They are women who are eligible only for family planning services, women who are eligible only for breast and cervical cancer services, persons enrolled in the Medically Needy program, and persons who are eligible for emergency Medicaid for aliens.[19]

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[10] Section 11.143, F.S.
[11] Section 11.147(2), F.S.
[12] Florida Auditor General, About the Florida Auditor General, available at: https://flauditor.gov/pages/aboutus.html#tab
[13] Sections 11.42 through 11.47, F.S.
[14] Agency for Health Care Administration, A Snapshot of Statewide Medicaid Managed Care 3.0, Available at: https://ahca.myflorida.com/content/download/25049/file/SMMC_Snapshot.pdf (last visited on Feb. 4, 2026).
[15] Section 409.969, F.S.
[16] *See* ss. 393.0662 and 393.0663, F.S., for statutory provisions relating to iBudget.
[17] Agency for Health Care Administration, Statewide Medicaid Managed Care (SMMC) New Program Highlight: Managed Medical Assistance v. Fee-For-Service, available at: https://ahca.myflorida.com/content/download/25693/file/Managed%20Medical%20Assistance%20Plan%20vs%20Fee-for-Service.pdf (last visited at Feb. 4, 2026).
[18] Section 409.972, F.S.
[19] Section 409.965, F.S.

Florida's Medicaid program, as of December 31, 2025, had 3,951,918 enrollees.[20] The enrollment for SMMC was 2,868,228, and enrollment in FFS was 1,079,806.[21]

Under either FFS or the SMMC, a recipient is entitled to all medical benefits provided by the State Plan.[22] The SMMC has four programs for providing those service:

- Managed Medical Assistance (MMA).
- Long-Term Care Managed Care (LTCMC).
- The Prepaid Dental Program.
- The pilot program for individuals with developmental disabilities.

MMA also provides for specialty plans to be provided in MMA.[23] Specialty plans are designed for specific populations.[24] There are currently specialty products for HIV/AIDS, serious mental illness, and child welfare.[25] Furthermore, SMMC provides for specialized care coordination and expanded benefits.[26]

Florida's Medicaid program, as of December 2025, is estimated to spend approximately $37.5 billion for state fiscal year 2025-26. Expenditures as of December 2025 for SMMC in state fiscal year 2025-2026 are estimated to be approximately $27.3 billion. Expenditures for FFS are estimated to be approximately $10.2 billion for state fiscal year 2025-2026.[27]

Encounter Data

Encounter data is recognized as essential for developing capitation rates for risk based managed care programs.[28] Pursuant to actuarial standards, encounter data is defined as "Information about an interaction between a provider of health care services and a member that is documented through the submission of a claim to a managed care organization (MCO) and shared between

[20] Agency for Health Care Administration, Medicaid Monthly Enrollment Report, available at: https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited Feb. 8, 2026).
[21] *Id*.
[22] Agency for Health Care Administration, *supra* note 17.
[23] Section 409.974(3), F.S. *Also see:* Agency for Health Care Administration, A Snapshot of the Florida Statewide Medicaid Managed Care Program, available at: https://ahca.myflorida.com/content/download/9126/file/SMMC_Snapshot.pdf?version=1 (last visited on Feb. 4, 2026).
[24] *Id*.
[25] Agency for Health Care Administration, A Snapshot of Statewide Medicaid Managed Care 3.0, available at: https://ahca.myflorida.com/content/download/25049/file/SMMC_Snapshot.pdf (last visited on Feb. 4, 2026).
[26] Agency for Health Care Administration, Statewide Medicaid Managed Care 3.0 Overview, available at: https://ahca.myflorida.com/content/download/25090/file/Statewide%20Medicaid%20Managed%20Care%20Full%20Deck_05212025%20.pdf (last visited Feb. 4, 2026).
[27] Social Services Estimating Conference – December 2025 Forecast, Medicaid Distribution: Managed Care and Fee for Service (December 22, 2025) available at: https://edr.state.fl.us/Content/conferences/medicaid/index.cfm (last visited Feb. 4, 2026).
[28] Cunningham, Houchens and Lewis, Encounter data standards: Implications for state Medicaid agencies and managed care entities from final Medicaid managed care rule, Milliman, (May 1, 2016), available at: https://www.milliman.com/en/insight/encounter-data-standards-implications-for-state-medicaid-agencies-and-managed-care-entiti (last visited on Feb. 4, 2026).

the MCO and the state Medicaid agency."[29] Encounter data is fundamental to measuring the required activities requested of managed care programs and for helping to determine capitation rates, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development.[30]

Providing validated encounter data to the U.S. Centers for Medicare & Medicaid Services (CMS) is a basic requirement for a state's implementation of Medicaid managed care. Failure to provide accurate and complete data can result in a state's federal financial participation (FFP) being reduced or otherwise impacted.[31] Florida statutes require Medicaid managed care plans to report encounter data to the AHCA's Medicaid Encounter Data System.[32] The AHCA annually performs an Encounter Data Validation Data Validation Study.[33]

The collection of encounter data may be affected when a managed care plan compensates providers with a capitated payment or other value-based compensation, which may or may not result in a claim for payment. Another complication may result when a provider subcontracts all or a portion of the delivery of health care benefits. There are also issues on how denied claims are treated for purposes of reporting encounter data.[34] Without a built-in payment incentive for providers, encounter data completeness can by compromised.[35, 36]

Achieved Savings Rebate

In 2011, with the implementation of SMMC, Florida Medicaid adopted an achieved savings rebate (ASR) mechanism for profit-sharing.[37] The ASR system has remained largely unchanged since then, except for a change in 2023 which recognized the need to return to the federal government a portion of the state's recoveries from the shared savings, based on the federal match percentage.[38] There was also a change in 2025 as to the auditing requirements by which the AHCA could notify the ASR auditor of deficiencies in the report and have them corrected before the audit is finalized.[39]

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[29] Actuarial Standards Board, Actuarial Standard of Practice No. 49, Medicaid Managed Care Capitation Rate Development and Certification (adopted March, 2015), p.2 available at: http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/#22-base-data (last visited on Feb. 4, 2026).
[30] Cunningham, Houchens and Lewis, *supra* note 28.
[31] 42 C.F.R. § 438.818
[32] Section 409.967(2)(e), F.S.
[33] Agency for Health Care Administration, Encounter Data Validation Studies, available at: https://ahca.myflorida.com/medicaid/medicaid-quality-activities-and-projects/encounter-data-validation-studies (last visited on Feb. 4, 2026).
[34] *Id.*at 13 and 15.
[35] *Id.*at A-10.
[36] Manatt Health, What's the Matter with Encounter Data? Common Issues and Actionable State Strategies for Improving a Critical Data Resource, presentation to National Association of Health Data Organization, 35th Annual Conference, (August 17, 2020), available at: https://www.nahdo.org/sites/default/files/2020-08/103-68%20Kevin%20McAvey%20What_s%20the%20Matter%20with%20Encounter%20Data__NAHDO%20Presentation_Aug%2016%202020.PDF (last visited on Feb. 8, 2026).
[37] Chapter 2011-134, Laws of Florida, p. 12-17.
[38] Chapter 2023-243, Laws of Florida, p.8. *See also:* Healthcare Appropriation, Senate Bill 2510 (June 9, 2023), p. 8, available at: https://www.flsenate.gov/Session/Bill/2023/2510/Analyses/s2510z1.HCA.PDF (last visited Feb. 6, 2026).
[39] Chapter 2025-204, Laws of Florida, p. 26.

The ASR process begins with each Medicaid managed care plan submitting to the AHCA by June 1 its audited financial statement for the preceding calendar year.[40] The AHCA contracts with an independent auditor which does a compliance audit of the various components of each plan's audited statement and which is used in calculating each calendar year's ASR for that plan.[41] Upon issuance of the compliance audit and the calculation of the ASR, the AHCA approves the report and it becomes final. A managed care plan is then required to pay any portion of its profit that must be shared with the state, if any, within 30 of the report being final.[42]

The portion of a managed care plan's profit that must be shared with the state is calculated by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

- One hundred percent of income up to and including five percent of revenue is to be retained by the plan.
- Fifty percent of income above five percent and up to ten percent is to be retained by the plan with the other 50 percent refunded to the state and adjusted for the federal match percentage.
- One hundred percent of income above 10 percent of revenue must be refunded to the state and adjusted for the federal match percentage.[43]

It is possible for the plan to retain an additional one percent of profit. To achieve this additional retention, the plan must meet quality objectives developed by the AHCA. The quality objectives are focused on complex, chronic health conditions which are associated with high-cost medical treatments.[44] The current SMMC contract contains a program for quality incentives based on eight measures.[45] In addition to this ASR bonus, a plan can receive a preference in auto-assignment of recipients[46] and payments from a two-percent financial withhold from the capitation rate, upon meeting such quality measures.[47]

Medical Loss Ratios (MLR)

Medical loss ratio calculation and reporting are requirements of the federal government for Medicaid managed care programs.[48] The numerator of the ratio is all incurred claims, expenditures that improve health quality, fraud prevention activities,[49] and amounts paid to providers under state-directed payments.[50] Deducted from incurred claims are overpayment

[40] Section 409.967(3)(a), F.S.
[41] Section 409.967(3)(b) and (c), F.S.
[42] Section 409.967(3)(h), F.S.
[43] Section 409.967(3)(f), F.S.
[44] Section 409.967(3)(g), F.S.
[45] Agency for Health Care Administration Model Contract, FPXXX, Attachment II, Update Oct. 1, 2025, p. 22-23, available at: https://ahca.myflorida.com/content/download/27248/file/Attachment%20II-%20-%20Core%20Contract%20Provisions%20Oct%202025.pdf (last visited Feb. 5, 2026).
[46] *Id.* at p. 23, authorized under s. 409.977(1), F.S.
[47] *Id.* at p. 23.
[48] MACPAC, Medical Loss Ratios in Medicaid Managed Care, Issue Brief, January 2022, available at: https://www.macpac.gov/wp-content/uploads/2022/01/Medical-loss-ratio-issue-brief-January-2022.pdf (last visited Feb. 5, 2026).
[49] 42 C.F.R. § 438.8(e)
[50] 42 C.F.R. § 438.8(e)(2)(iii)(C)

recoveries from network providers and any prescription drug rebates received and accrued by a managed care plan.[51]

The denominator is adjusted premium revenue received by the plan.[52] Capitation payments for required services under the contract is the largest component of premium revenue. Revenue does not include incentive payments and pass-through payments. Federal, state, and local taxes and licensing and regulatory fees are deducted from adjusted premium revenue.[53]

CMS requires that a state must have oversight of a managed care plan's MLR reporting.[54] In addition, when calculating a plan's capitation rate, there are various MLR-related standards that must be included to meet the required "actuarial soundness" standard.[55] However, states are not required to, but may, implement a minimum MLR.[56] A state can apply a required MLR in the aggregate or to different populations or a portion of the contract.[57]

CMS has been regularly publishing MLR reports.[58] The AHCA has been collecting the required reports from the health plans and submitting them to CMS by its Financial Monitoring section.[59] The AHCA, in the standard contract with the health plans, requires them to prepare, deliver, and retain copies of the requisite federal MLR report for their particular plan.[60]

Section 409.967(4), F.S., authorizes the AHCA to calculate MLRs for SMMC managed care plans if required to do so as a condition of a Medicaid waiver. The statute requires that the method for calculating MLRs must classify expenditures in a manner consistent with 45 C.F.R. part 158,[61] except that:

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[51] Prescription drug rebates must be deducted if received by the health plan directly or a pharmacy benefit manager. *See:* MACPAC, *supra* note 48 at p. 8.
[52] *Id.* at p. 3.
[53] *Id.*
[54] Centers for Medicare & Medicaid Services, CMCS Informational Bulletin, Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio, June 5, 2020, available at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib060520_new.pdf (last visited Feb. 5, 2026).
[55] 42 C.F.R. § 438.4(b)(9) and 42 C.F.R. § 439(5)(b)(5)
[56] Centers for Medicare & Medicaid Services, *supra* note 54 at Q.2.
[57] 42 C.F.R. § 439.8(i)
[58] Centers for Medicare & Medicaid Services, Data.Medicaid.gov, available at: https://data.medicaid.gov/dataset/743f9f04-4473-41e2-9da2-9a89db65ee55#data-table (last visited Feb. 5, 2026).
[59] Agency for Health Care Administration, Financial Monitoring webpage, available at: https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-program-finance/financial-monitoring (last visited Feb. 5, 2026).
[60] Agency for Health Care Administration, *supra* note 45 at pp. 137, 143, 258. The reporting seems to be done in the context of the ASR reporting and calculation. Agency for Health Care Administration, Plan Communication, RCN 2024-03, Re: Achieved Savings Rebate (ASR) Financial Report – Medical Loss Ratio Comparison, (April 17, 2024), available at: https://ahca.myflorida.com/content/download/27209/file/RCN%202024-03%20ASR%20Financial%20Template%20-%20MLR%20Comparison_04.17.2024.pdf (last visited Feb. 6, 2026).
[61] This portion of the Code of Federal Regulations was adopted to implement MLR requirements for health insurance issuers under the Public Health Service Act in order to address the treatment of "mini-med" and expatriate policies under these regulations for years after 2011; modify the way the regulations treat ICD-10 conversion costs; change the rules on deducting community benefit expenditures; and revise the rules governing the distribution of rebates by issuers in group markets. *See:* The Federal Register, Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, available at: https://www.federalregister.gov/documents/2011/12/07/2011-31289/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act (last visited Feb. 9, 2026).

- Funds provided by the managed care plans to graduate medical education institutions to underwrite the costs of residency positions must be classified as MLR medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients; and
- Before final determination of the MLR for any period, a managed care plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as an MLR medical expenditure for the period.

According to the AHCA, federal CMS has not approved the two MLR exceptions listed above for Florida's waiver that authorizes SMMC. Therefore, those exceptions for MLR expenditures have never been implemented.[62]

Reporting of Administrative Subcontractors and Affiliates

As part of the standard contract with Medicaid health plans, the AHCA obligates them to a list of reports which must be prepared and submitted electronically, either on a monthly, quarterly, or annual basis.[63] The required reports are designated in the Managed Care Plan Report Guide.[64] There are 28 reports on the contract list.[65] The AHCA maintains a website that contains instructions, templates, and submission directions.[66] The AHCA also regularly sends communications to the health plans as to technical details, changes, or corrections to reporting.[67]

One of the reports requires Medicaid managed care plans to disclose and file their administrative subcontractors and affiliates.[68] This report is to be filed quarterly.[69] The report is publicly available.[70] In the instructions for the report, the following definition of "affiliate" is used:

> For purposes of this report, "affiliate" or "affiliated person" means:
> (1) Any person or entity who directly or indirectly manages, controls, or oversees the operation of the Managed Care Plan, regardless of whether such person or entity is a partner, shareholder, owner, officer, director, agent, or employee of the entity;

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[62] Email from staff of the Agency for Health Care Administration to staff of the Senate Committee on Health Policy, (Feb. 9, 2026) (on file with the Senate Health Policy Committee).
[63] Agency for Health Care Administration, *supra* note 45 at p. 228-229.
[64] *Id.* at p. 243.
[65] *Id.* at p. 229-230.
[66] Agency for Health Care Administration, 2025-2030 Medicaid Managed Care Plan Report Guide, available at: https://ahca.myflorida.com/site/medicaid/statewide-medicaid-managed-care/reports-guides/2025-2030-medicaid-managed-care-plan-report-guide (last visited Feb. 6, 2026).
[67] Agency for Health Care Administration, Agency Communications to SMMC Plans, Effective 2018-2024 website, available at: https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/agency-communications-to-smmc-plans-effective-2018-2024 (last visited Feb. 6, 2026).
[68] Agency for Health Care Administration, *supra* note 45 at pp. 212 and 229.
[69] *Id.* at p. 229.
[70] Agency for Health Care Administration, Administrative Subcontractors and Affiliates Report, 4th quarter of 2025, available at: https://ahca.myflorida.com/content/download/28160/file/Administrative_Subcontractors_and_Affiliates_Report_Cumulative_Q4%202025%20PDF.pdf (last visited on Feb. 8, 2026).

> (2) Any person or entity who has a financial relationship with the Managed Care Plan as defined by 42 CFR 438.320(1); and/or
> (3) An individual or entity who meets the definition of an affiliate as defined in 48 CFR 19.101.[71]

The report is described as informational only.[72] If a subcontractor or affiliate has been reported on the provider network file, then it is not to be included in this report.[73] The report requires the managed care plans to describe the payment methodology to such subcontractors or affiliates.[74]

Under federal regulations, there is a definition of "financial relationship" as follows:

> Financial relationship means—
> (1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or
> (2) A compensation arrangement with an entity.[75]

This definition is applicable to 42 C.F.R. part 438, which is the section of the federal regulations applicable to managed care contracting for state Medicaid programs.

Federal law requires the AHCA to obtain disclosure from any person or entity who, directly or indirectly, has a controlling interest or ownership interest in the managed care entity. Any entity that provides services under the managed care contract and who has a controlling interest or ownership interest in the managed care entity, or with which the managed care entity has a controlling interest or ownership interest, must be disclosed.[76] The relationship is traced through spouse, parent, child, or sibling.[77] The threshold for reporting an ownership interest is five percent or greater.[78] The disclosures are to be made upon:

- The entity submitting a proposal during the procurement process,
- The entity executing a contract with the state,
- Renewal or extension of the contract, and
- Within 35 days of a change of ownership.[79]

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[71] Agency for Health Care Administration, SMMC Managed Care Report Guide Administrative Subcontractor and Affiliates Report Summary, Feb. 1, 2025, at p. 1, fn.2, available at: https://ahca.myflorida.com/content/download/25779/file/AdministrativeSubcontractorsandAffliatesReportSummary_2.1.2025.pdf (last visited Feb. 6, 2026).
[72] *Id.*at p.1.
[73] *Id.*
[74] *Id.*at p. 3.
[75] 42 C.F.R. § 438.320
[76] 42 C.F.R. § 455.104. This section likewise applies to providers in the FFS and SMMC. *See also* 42 C.F.R. § 438.608(c)(2).
[77] 42 C.F.R. § 455.104(b)(2)
[78] *Id.*
[79] 42 C.F.R. § 455.104(c)(3)

A managed care plan that fails to make such disclosures can cause the state to lose the federal financial participation paid to that health plan.[80]

Section 409.966(3)(b), F.S., provides a definition of the term "business relationship," as follows:

> "Business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, that exists for the purpose of making a profit.

When applying for a managed care plan contract via SMMC procurement, a plan is required to disclose all these business relationships. The AHCA may not select plans in the same region which have a business relationship with each other. Failure to disclose a business relationship can result in disqualification in the procurement.[81]

Section 409.901(1), F.S., provides a definition of "affiliate," which is:

> "Affiliate" or "affiliated person" means any person who directly or indirectly manages, controls, or oversees the operation of a corporation or other business entity that is a Medicaid provider, regardless of whether such person is a partner, shareholder, owner, officer, director, agent, or employee of the entity.

Medicaid providers and managed care plans are required to report within 30 days any change of any principal, officer, director, agent, or affiliated person, and when ownership changes by five percent or more.[82] There is also a requirement that such persons must have a level 2 background check.[83]

The AHCA may deny participation in the Medicaid program to an applicant or revoke any current provider agreement or contract if an affiliated person, or owner of five percent or more (or any of the others previously described) has:

- Failed to pay any outstanding overpayments,
- Makes a false representation on an application,
- Fails to disclose a controlling interest or ownership interest,
- Has been excluded , suspended, terminated or involuntarily withdrawn from participation, in the Florida Medicaid program, or any other governmental or private health insurance program, or

[80] 42 C.F.R. § 455.104(f). This section likewise applies to providers in the FFS and SMMC.
[81] Section 409.966(2), F.S.
[82] Section 409.907(2)(k), F.S.
[83] Section 409.907(8)(a)2., F.S. However, if such persons are members of a unit of local government, or any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more, they may be relieved of the obligation for background screening. s. 409907(8)(c), F.S.

- Has been found by any licensing, certifying or professional board or agency to have violated the standards or condition of such licensure or certification.[84]

Also, the AHCA may likewise suspend or terminate a provider agreement or contract if any of the following occurs to an affiliated person or five percent or greater owner, principal, officer, director, agent, managing employee, of a provider of services to the Medicaid program:

- He or she is terminated by any state Medicaid program or Medicare, [85] or
- He or she is convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under ss. 408.809(4), 409.907(10), or 435.04(2), F.S.[86]

The AHCA must determine whether the entity participated or acquiesced in the reason such affiliated person, or five percent owner (or any of the others previously described), was terminated, suspended, or convicted. If the AHCA imposes any administrative sanction because of the foregoing actions of a principal, officer, director, agent, managing employee, affiliated person, or five percent owner, then it must notify the entity.[87]

Pharmacy Benefit Managers and the Prescription Drug Supply Chain

Health insurers, HMOs, or self-insured employers may contract with pharmacy benefit managers (PBMs) to manage their prescription drug benefits to reduce the overall costs of prescription drugs.[88] PBMs administer drug benefits and negotiate rebates with drug manufacturers, provide mail-order pharmacy services, create drug formularies, provide disease management, conduct drug utilization management, and adjudicate claims. The PBMs, or their affiliated group purchasing organization (GPO), may negotiate rebates with pharmaceutical manufacturers, generally for brand-name and specialty drugs, in exchange for placement on a health plan's formulary.[89]

In recent years, the affordability of prescription drugs has gained national attention, resulting in PBMs and drug manufacturers coming under scrutiny as policymakers have attempted to understand their role in the drug supply chain. Many stakeholders (drug manufacturers, drug wholesalers, pharmacy services administrative organizations, pharmacies, PBMs, health plans, employers, and consumers) are involved with, and pay different prices for, prescription drugs as they move from the drug manufacturer to the ultimate consumer.

Once a prescription drug has been developed and approved for sale, drug manufacturers set their price. The prices that maximize manufacturers' revenues from brand-name drugs depend on factors such as exclusive sales rights for newly approved brand-name products, the prevalence of health insurance coverage for prescription drugs, and buyers' willingness to pay for brand-name

[84] Section 409.907(10), F.S.
[85] Section 409.907(14), F.S.
[86] Section 409.907(13), F.S.
[87] Section 409.908(24), F.S.
[88] Commonwealth Fund, *Pharmacy Benefit Managers and Their Role in Drug Spending* (Apr. 22. 2019), available at: https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending (last visited Jan. 28, 2026).
[89] *Id.*

drugs in various market segments.[90] Brand-name drugs often face competition from other drugs with similar clinical effects, which can put downward pressure on prices. The combination of exclusive sales rights and insurance coverage can give drug manufacturers considerable leverage in their price negotiations with purchasers, which may lead to higher prices.[91]

It can be difficult to determine the final price of a prescription drug. The final price of a drug may include rebates and discounts to insurers, health maintenance organizations (HMOs), or PBMs or their GPOs. Market participants, such as drug wholesalers, may add their own mark-ups and fees, and drug manufacturers may offer direct consumer discounts, such as prescription drug coupons that can be redeemed when filling a particular prescription at a pharmacy.[92]

Independent community pharmacies represent about 35 percent of all retail pharmacies in the U.S.[93] Many of the independent pharmacies contract with pharmacy services administrative organizations (PSAO) to interact on their behalf with other stakeholders, such as drug wholesalers and third-party payers like large private and public health plans and their PBMs.[94] The PSAOs develop networks of pharmacies, and negotiate on their behalf with third-party payers, such as PBM's, on the pharmacy's behalf.[95] A PSAO may also provide credentialling and compliance assistance, claims reconciliation, and provide support relating to PBM audits of pharmacy.[96]

Compensation of PBMs

The PBMs receive compensation from health plans or employers for their services in a variety of ways. For example, a health plan may opt for an administrative fee contract, in which they pay the PBM directly for all of the services provided.[97] Some health plans may choose to use a spread pricing model in which the health plan pays the PBM a set price for each prescription filled, and the PBM retains the difference between the price paid by the health plan and the price paid to the pharmacy as a form of compensation.[98] In addition, PBMs may retain a portion of drug manufacturer rebates to offset the fees health plans would otherwise pay. PBMs may obtain significant rebates from manufacturers, and are reported to often pass on 90 to 95 percent of

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[90] Congressional Budget Office, Alternative Approaches to Reducing Prescription Drug Prices (Oct. 2024) Alternative Approaches to Reducing Prescription Drug Prices, available at: https://www.cbo.gov/publication/60812 (last visited Jan. 25, 2026).
[91] *Id.*
[92] Reynolds, Ian*, et. al., The Prescription Drug Landscape, Explored (Mar. 2019).* The Pew Charitable Trusts.
[93] National Community Pharmacists Association, (Oct. 15, 2023) NCPA Releases 2023 Digest Report, available at: https://ncpa.org/newsroom/news-releases/2023/10/15/ncpa-releases-2023-digest-report (last visited Jan. 23, 2026).
[94] General Accounting Office*, The Number, Role, and Ownership of Pharmacy Services Administrative Organizations* (GAO-13-176) (Feb 28, 2013), available at: https://www.gao.gov/products/GAO-13-176 (last visited Jan. 28, 2026).
[95] Pace, Scott, The Role and Value of Pharmacy Services Administrative Organizations, 2022, available at: https://content.naic.org/sites/default/files/call_materials/The%20Role%20and%20Value%20of%20Pharmacy%20Services%20Administrative%20July%202022.pdf (last visited Jan. 20, 2026).
[96] *Id.*
[97] Mercer, Understanding the Debate over PBMs, Aug. 1, 2024, available at: https://www.mercer.com/en-us/insights/us-health-news/understanding-the-debate-over-pbms/ (last visited Feb. 5, 2026).
[98] *Id.*

rebates to the plan sponsor.[99] An increasing number of PBMs that are using "pass-through" pricing at mail order and specialty.[100] In these instances, they will charge a dispensing fee, an administrative fee and sometimes shipping charges, all of which helps to offset the revenue lost by moving away from spread pricing.[101] Generally, a contract between a PBM and a health plan or an employer specifies the amount a plan or an employer will pay a PBM for brand name and generic drugs and specify certain savings guarantees.[102]

Vertical Integration Relating to PBM Ownership*[103]*

The "Big Three" PBMs – CVS Caremark, Express Scripts, and OptumRx – manage approximately 80 percent of prescription drug claims for approximately 270 million people.[104] Coupled with the next three largest PBMs – Humana Pharmacy Solutions, MedImpact, and Prime – they represent 94 percent of prescription drug claims in the U.S. (Collectively, these six PBMs are sometimes known as the "Big Six.")

Vertical integration is the combination into one company of at least two stages of production normally performed by separate companies. The Big Six PBMs have become vertically integrated within entities that provide a broad range of services across the pharmaceutical supply chain and other segments of the health care sector, as illustrated in Figure 1.[105]

The three largest PBMs are each affiliated with a health plan and a pharmacy, so the parent company owns or controls up to three stages or more of the drug supply chain. Some PBMs are also affiliated with health care providers, such as retail clinic services. Vertical integration may allow a company to combine operations between stages of production and pass the savings from smaller transaction costs to their customers. Various PBMs are now vertically integrated with upstream suppliers of goods and services, including drug private labelers[106] and provider groups. PBMs are also vertically integrated with midstream distributors, including retail, mail order, and specialty pharmacies.

Downstream, PBMs are vertically integrated with large health insurers which, through their health plans and plan sponsor services, provide health coverage for hundreds of millions of

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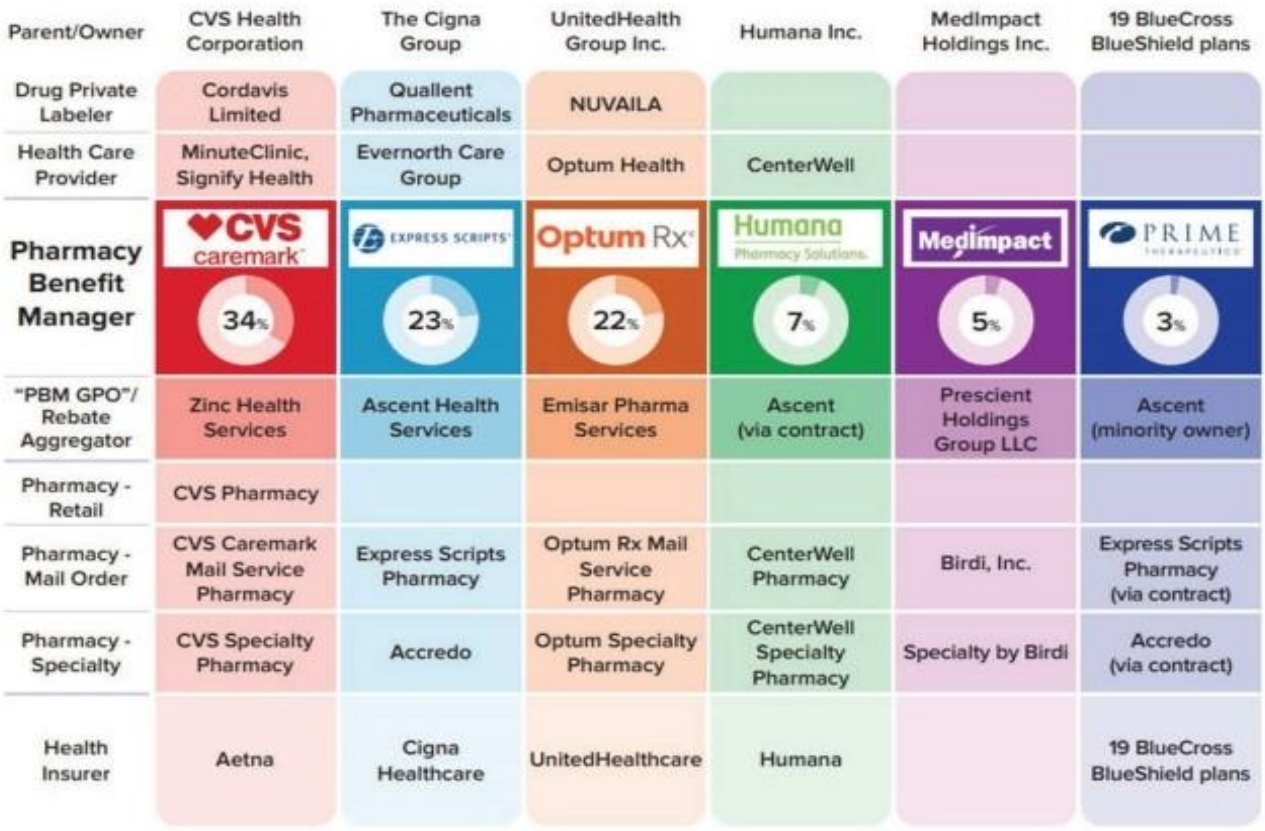
[99] Avalere Health, The Role of PBMs in the US Healthcare System, June 2025, available at: https://advisory.avalerehealth.com/wp-content/uploads/2025/06/The-Role-of-PBMs-in-the-US-Healthcare-System_White-Paper.pdf (last visited Jan. 28, 2026).
[100] *Id.*
[101] *Id.*
[102] Health Affairs, *Policy Options To Help Self-Insured Employers Improve PBM Contracting Efficiency*, May 29, 2019, available at: https://www.healthaffairs.org/content/forefront/policy-options-help-self-insured-employers-improve-pbm-contracting-efficiency (last visited Feb. 10, 2026).
[103] National Association of Insurance Commissioners, A GUIDE TO UNDERSTANDING PHARMACY BENEFIT MANAGER AND ASSOCIATED STAKEHOLDER REGULATION, Sep. 9, 2023, available at: https://content.naic.org/sites/default/files/PBM%252520White%252520Paper%252520Draft%252520Adopted%252520B%252520Committee%25252011-2-23_0.pdf (last visited Jan. 18, 2026).
[104] Kaiser Family Foundation, What to Know about Pharmacy Benefit Managers and Federal Efforts at Regulation, Dec. 18, 2025, available at: https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/ (last visited December 20, 2025).
[105] *Id.*
[106] Freyr Blog, Private Labeling in Pharma: Challenges and Solutions, Apr. 20, 2023, available at: https://www.freyrsolutions.com/blog/private-labeling-in-pharma-challenges-and-solutions (last visited Jan. 17, 2026).

Americans. Due to the high degree of consolidation and vertical integration, the dominant PBMs can often exercise significant control over which drugs are available, at what price, and which pharmacies patients can use to access their prescribed medications.[107]

Figure 1. PBM Ownership and Vertical Integration



PBM Payment of Affiliate Pharmacies*[108]*

In 2022, a federal report found that commercial health plans paid affiliated pharmacies roughly 80 to 90 percent more than unaffiliated pharmacies for abiraterone acetate (generic Zytiga) and imatinib mesylate (generic Gleevec). Pharmacies affiliated with the Big Three PBMs were often paid 20 to 40 times National Average Drug Acquisition Cost (NADAC),[109] and significantly more than unaffiliated pharmacies, for the two case studies of specialty generic drugs for cancer treatment for both the commercial and Medicare Part D payer groups.[110] For example,

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[107] *Id.*

[108] Federal Trade Commission, Office of Policy Planning, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, Interim Staff Report, July 2024, https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf (last visited Jan. 20, 2026).

[109] The (NADAC) is an index of drug acquisition costs based on surveys of invoices voluntarily provided primarily by small, independent pharmacies. See Retail Price Survey, MEDICAID.GOV, Jan. 5, 2026, available at: https://www.medicaid.gov/medicaid/prescription-drugs/retail-price-survey/index.html (last visited Jan. 19, 2026).

[110] Federal Trade Commission, *supra* note 108 at p. 14. Gross reimbursement to a pharmacy is the sum of the amounts paid by the PBM, the patient, and any other payers (e.g., a secondary insurer), as applicable. NADAC is based on the maximum NADAC observed each year for the most commonly dispensed dose of the drug. NADAC was not always available for other

commercial health plans reimbursed affiliated pharmacies for abiraterone acetate (generic Zytiga) in 2022 more than $5,800 per month, on average—or approximately 25 times the $229 acquisition cost reflected by NADAC. For the second drug, imatinib mesylate (generic Gleevec), commercial health plan reimbursements to affiliated pharmacies averaged roughly $2,700 per month in 2022, more than 40 times higher than the NADAC acquisition cost of $66.

Payments to affiliated pharmacies by a PBM-affiliated fully insured health plan represent internal transfers from the PBM's vertically integrated insurer to its pharmacies. These internal transfers may have implications for medical loss ratios (MLRs), which are regulated under the federal Affordable Care Act and represent the percentage of premium revenue that health plans are required to spend on clinical care and quality improvement initiatives (80 to 85 percent) rather than administrative expenses and contributions to plan profits.[111]

Industry experts have raised concerns that vertically integrated healthcare entities can game MLR requirements by shifting funds between affiliated entities. For example, if an affiliated insurer pays an inflated price for a specialty generic to its affiliated pharmacy, the higher payment is credited as spending on clinical care and helps the affiliated insurer satisfy its MLR obligations. At the same time, the payment is credited as revenue to the affiliated pharmacy. Because the pharmacy's revenue has no bearing on the affiliated insurer's MLR calculation, this transfer payment allows the vertically integrated PBM-insurer-pharmacy entity to retain revenue and profits while formally satisfying the MLR rule—but without providing the clinical care and quality improvements that the rule is meant to promote.

Private Label Drugs

Private labeling refers to the practice of a company manufacturing a product which is then sold under another company's brand name. Private labeling is a common practice used by companies to expand their product offerings without having to invest in the research and development required to create a new drug product. Essentially, the manufacturer produces the product and allows another company to attach its own label to it.

Biosimilar drugs[112] can provide lower cost options for federally approved brand name drugs that reduce the price per prescription, on average, by 40 percent.[113] For example, Humira, characterized as the world's best-selling drug, had an average gross cost of $7,000 per month.[114]

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doses of the drug. The acquisition costs for those drugs may be lower or higher than the NADAC for the most commonly dispensed dose.

[111] *Id.* at p. 31., noting MLR statutory requirement of 80 percent for individual and small group health plans and 85 percent for large group health plans. MLRs are regulated for commercial fully insured health plans.

[112] A biosimilar drug is highly similar and has no clinically meaningful differences when compared to the original FDA-approved biological product (reference product). Biosimilar drugs are made with the same types of living organism as the reference product. *See* U.S. Food and Drug Administration, Overview of Biosimilar Products, available at: https://www.fda.gov/media/151058/download?attachment (last visited Jan. 10, 2026).

[113] Sequoia Blog, Foreword, How Biosimilars Can Significantly Reduce Pharmacy Costs for Employers, Dec. 18, 2024, available at: https://www.sequoia.com/2024/12/how-biosimilars-can-significantly-reduce-pharmacy-costs-for-employers/ (last visited Jan. 27. 2026). Many biosimilars lack interchangeability status, meaning the ability for the dispensing pharmacy to automatically substitute the biosimilar for the original, brand name product without additional approval from the prescribing provider.

[114] *Id.*

In 2023, CVS Health launched Cordavis, an international subsidiary that coproduces biosimilars with manufacturers, such as Sandoz.[115] Optum and ESI soon followed CVS Health by announcing partnerships with third-party biosimilar procurers and private-label manufacturers to coproduce and co-label their own biosimilars to prefer on their formularies market.[116] In April 2024, Cigna Group's Evernorth Health Services announcing the production of a $0 copay Humira biosimilar via its subsidiary Quallent Pharmaceuticals, a private-label distributor.[117]

For 2025, the Big Three PBMs shifted national formularies to favor their private-label biosimilars over Humira and its many biosimilar competitors.[118] Nearly all marketed Humira biosimilars were excluded from the larger PBMs' 2025 formularies.[119] For 2025, Humira (original flavor) has or will no longer be placed on PBMs' standard formularies, and most marketed biosimilars will be excluded from the 2025 formularies.[120] Instead, each PBM's formulary will give plan sponsors the option of a high-list-price biosimilar, a lower-priced private label product, and a low-list-price unbranded biosimilar.[121]

Due to the availability of multiple biosimilars in the market for Humira, there was an 80 percent cost savings per prescription for employer plans, even without rebates.[122] The PBMs and manufacturing firms may share remaining revenues with contracted distributors, generating additional income back to the PBM. A product sold at an 80 percent discount of wholesale acquisition cost (WAC) discount leaves 20 percent left for revenue sharing with the PBM's distributor and biosimilar manufacturer.[123] This new income stream to the PBM's parent can offset potential losses to rebate revenue.[124]

The addition of a manufacturing subsidiary for a PBM is advantageous since it provides better cost control and supply chain dynamics, and allows the PBM to align an entire product distribution chain in their favor, excluding competitors and preferring their designated agents.[125] However, this may not always result in the lowest net cost drug product available for employer plans.[126]

Recent Federal Enforcement Actions Against PBMs

On February 4, 2026, the Federal Trade Commission (FTC) announced a settlement with Express Scripts, Inc., and its affiliated entities (collectively known as ESI). The settlement

[115] Drug Channels, When Payers Become Producers: Inside the PBM Private-Labeling Trend, Aug. 16, 2024, available at: https://www.drugchannels.net/2024/08/when-payers-become-producers-inside-pbm.html (last visited Jan. 20, 2026).
[116] *Id.*
[117] *Id.*at *34.*
[118] *Id.*
[119] *Id.*
[120] *Id.*
[121] *Id.*
[122] Sequoia Blog, *supra* note 113 at p. 32.
[123] BR&R Biosimilars Review and Report, Employer Plans, Private-Label Biosimilars, Little Transparency, Jan. 19, 2025, available at: https://biosimilarsrr.com/2025/02/19/employer-plans-private-label-biosimilars-little-transparency/ (last visited Jan 18, 2026).
[124] *Id.*
[125] Mehr, Stanton R., Will the emerging private-label market access channel help or hinder biosimilar market access?, Aug. 2025, available at: https://www.jmcp.org/doi/epdf/10.18553/jmcp.2025.31.8.824 (last visited Jan. 19, 2026).
[126] *Id.*

requires ESI to adopt fundamental changes to its business practices that increase transparency, are expected to reduce insureds' out-of-pocket costs for drugs like insulin by up to $7 billion over 10 years, and bring millions of dollars in new revenue to community pharmacies each year.

The FTC's settlement[127] resolves the FTC lawsuit[128, 129] against ESI, which alleges that ESI artificially inflated the list price of insulin drugs by using anticompetitive and unfair rebating practices, and impaired patients' access to lower list price products, ultimately shifting the cost of high insulin list prices to vulnerable patients.

The FTC's enforcement action against ESI, as well as Caremark Rx and OptumRx, alleges that the PBMs created a system that artificially drove up the list prices of drugs by preferencing rebates. The complaint alleges that this system pushed insulin manufacturers, among others, to compete for preferred formulary coverage based on the size of rebates off the list price rather than net price, which ultimately benefitted the PBMs, including ESI, which keep a portion of the inflated rebates. According to the FTC's complaint, the inflated list prices hurt patients whose out-of-pocket payments like copayments and coinsurance are tied to the list price of the drug. ESI, under the FTC's proposed consent order, has agreed to:

- Stop preferring on its standard formularies high wholesale acquisition cost versions of a drug over identical low wholesale acquisition cost versions;
- Provide a standard offering to its plan sponsors that ensures that members' out-of-pocket expenses will be based on the drug's net cost, rather than its artificially inflated list price;
- Provide covered access to TrumpRx as part of its standard offering upon relevant legal and regulatory changes;
- Provide full access to its Patient Assurance Program's insulin benefits to all members when a plan sponsor adopts a formulary that includes an insulin product covered by the Patient Assurance Program unless the plan sponsor opts out in writing;
- Provide a standard offering to all plan sponsors that allows the plan sponsor to transition off rebate guarantees and spread pricing;
- Delink drug manufacturers' compensation to ESI from list prices as part of its standard offering;
- Increase transparency for plan sponsors, including with mandatory, drug-level reporting, providing data to permit compliance with the Transparency in Coverage regulations, and disclosing payments to brokers representing plan sponsors;

[127] Federal Trade Commission, DECISION AND ORDER AS TO RESPONDENTS EXPRESS SCRIPTS, INC., EVERNORTH HEALTH, INC., MEDCO HEALTH SERVICES, INC., AND ASCENT HEALTH SERVICES LLC, available at: https://www.ftc.gov/system/files/ftc_gov/pdf/d09437caremarkproporder-esiresps.pdf (last visited Feb. 8, 2026).
[128] Federal Trade Commission, Press Release, Sept. 20, 2024, "FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices | Federal Trade Commission," available at: https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices (last viewed Feb. 4, 2026).
[129] The FTC's administrative complaint alleges that CVS Health's Caremark, Cigna's ESI, and United Health Group's Optum, and their respective GPOs, Zinc Health Services, Ascent Health Services, and Emisar Pharma Services, have abused their economic power by rigging pharmaceutical supply chain competition in their favor, forcing patients to pay more for life-saving medication. *See:* https://www.ftc.gov/system/files/ftc_gov/pdf/612314.2024.11.26_part_3_administrative_complaint_-_revised_public_redacted_version.pdf (last visited Feb. 10, 2026).

- Transition its standard offering to retail community pharmacies to a more transparent and fairer model based on the actual acquisition cost for a drug product plus a dispensing fee and additional compensation for non-dispensing services;
- Promote the standard offerings to plan sponsors and retail community pharmacies; and
- Reshore its group purchasing organization Ascent from Switzerland to the United States, which will bring back to the United States more than $750 billion in purchasing activity over the duration of the order.

In a statement issued on September 20, 2024, the FTC's Bureau of Competition stated that the PBMs are not the only potentially culpable actors – the Bureau also remains deeply troubled by the role drug manufacturers like Eli Lilly, Novo Nordisk, and Sanofi play in driving up list prices of life-saving medications like insulin.[130] Further, the statement indicated that all drug manufacturers should be on notice that their participation in the type of conduct challenged here raises serious concerns, and that the Bureau of Competition may recommend suing drug manufacturers in any future enforcement actions.

Florida Regulation of Pharmacy Benefit Managers

The Office of Insurance Regulation (OIR)[131] is responsible for the regulation of all activities of insurers and other risk-bearing entities, including licensure, rates, policy forms, market conduct, claims, solvency, administrative supervision, pursuant to the Florida Insurance Code (code).[132] The OIR also regulates PBMs. A PBM operating in Florida must be registered with OIR, pursuant to s. 624.490, F.S., and hold a valid certificate of authority (COA) as an insurance administrator.[133]

A PBM is a person or an entity doing business in this state which contracts to administer prescription drug benefits on behalf of a pharmacy benefits plan or program. The term includes, but is not limited to, a person or an entity that performs one or more of the following services on behalf of such plan or program:

- Pharmacy claims processing.
- Administration or management of a pharmacy discount card program.
- Managing pharmacy networks or pharmacy reimbursement.
- Paying or managing claims for pharmacist services provided to covered persons.
- Developing or managing a clinical formulary, including utilization management or quality assurance programs.
- Pharmacy rebate administration.
- Managing patient compliance, therapeutic intervention, or generic substitution programs.

[130] Federal Trade Commission, Statement of FTC Bureau of Competition Deputy Director Rahul Rao on Lawsuit Against PBMs and the Role of Drug Manufacturers in Distorting Competition in the U.S Drug Distribution System, available at: https://www.ftc.gov/system/files/ftc_gov/pdf/insulin-manufacturing-statement.pdf, Sept. 20, 2024 (last visited Feb. 8, 2026).
[131] The OIR is an office under the Financial Services Commission (commission), which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. The commission is not subject to control, supervision, or direction by the Department of Financial Services in any manner, including purchasing, transactions involving real or personal property, personnel, or budgetary matters. *See* s. 20.121(3), F.S.
[132] Section 20.121(3)(a)1., F.S.
[133] Section 626.8805(1), F.S.

- Administration or management of a mail-order pharmacy program.[134]

A pharmacy benefit plan or program[135] includes, but is not limited to, HMOs, health insurers, self-insured employer health plans, discount card programs, and government-funded health plans, including the Statewide Medicaid Managed Care program established pursuant to part IV of ch. 409, F.S., and the state group insurance program pursuant to part I of ch. 110, F.S.[136] The term excludes such a plan or program under ch. 440, F.S., which is Florida's workers' compensation law.

Requirements for Contracts Between a PBM and a PBM Plan or Program

A contract between PBM and a pharmacy benefit plan or program must include terms that ensure compliance with the requirements of s. 626.8825(2), F.S., and, except to the extent not allowed by law, must supersede any contractual terms to the contrary. These requirements include, but are not limited to, requiring a PBM to:

- Use a pass-through pricing model, which is a payment model used by a PBM in which the payments made by the pharmacy benefits plan to the PBM for the covered outpatient drugs are:
  - Equivalent to the payments the PBM makes to a dispensing pharmacy or provider for such drugs, including any contracted professional dispensing fee between the pharmacy benefit manager and its network of pharmacies. Such dispensing fee would be paid if the pharmacy benefits plan was making the payments directly.
  - Passed through in their entirety by the pharmacy benefits plan or program or by the PBM to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation.
- Exclude terms that allow for the engagement in the practice of spread pricing unless the PBM passes along the entire amount of such difference to the pharmacy benefits plan. Spread pricing is the practice in which a PBM charges a pharmacy benefits plan or program a different amount for pharmacist services than the amount the pharmacy benefit manager reimburses a pharmacy for such pharmacist services.
- Pass 100 percent of all prescription drug manufacturer rebates received to the pharmacy benefits plan, if the contractual arrangement delegates the negotiation of rebates to the PBM, for the sole purpose of offsetting defined cost sharing and reducing premiums of covered persons. Any excess rebate revenue after the PBM and the pharmacy benefits plan have taken all actions required pursuant to this provision must be used for the sole purpose of offsetting copayments and deductibles of covered persons. This provision does not apply to contracts involving Medicaid managed care plans.
- Include network adequacy requirements that meet or exceed Medicare Part D program standards for convenient access to the network pharmacies and that:
  - Do not limit a network to solely include affiliated pharmacies;
  - Require a PBM to offer a provider contract to licensed pharmacies physically located on the physical site of providers that are:

[134] Section 626.88(6), F.S.
[135] Section 626.8825(1)(u), F.S.
[136] *Id*.

    - Within the geographic service area of the pharmacy benefits plan or program and that have been specifically designated as essential providers by the Agency for Health Care Administration (agency);
    - Designated as cancer centers of excellence regardless of the geographic service area of the pharmacy benefits plan or program;
    - Organ transplant hospitals, regardless of the geographic service area of the pharmacy benefits plan or programs;
    - Hospitals licensed as specialty children's hospitals; or
    - Regional perinatal intensive care centers, regardless of the geographic service area of the pharmacy benefits plan or program.
- Not require a covered person to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the pharmacy benefit manager's network for the covered person's pharmacy benefits plan or program.
- Not requiring a covered person to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs; and
- Not offering or implementing pharmacy networks that require a covered person, or provide to a covered person a promotional item or an incentive – defined as anything other than a reduced cost-sharing amount or enhanced quantity limit allowed under the benefit design for a covered drug – to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs.

Requirements for Contracts Between a PBM and a Participating Pharmacy

A contract between PBM and a participating pharmacy must include terms that ensure compliance with the requirements of s. 626.8825(3), F.S., which include, but are not limited to:

- At the time of adjudication for electronic claims or the time of reimbursement for nonelectronic claims, the PBM must provide the pharmacy with a remittance, including such detailed information as is necessary for the pharmacy or pharmacist (pharmacy) to identify the reimbursement schedule for the specific network applicable to the claim and which is the basis used by the PBM to calculate the amount of reimbursement paid.
- A prohibition of financial clawbacks, reconciliation offsets, or offsets to adjudicated claims. A PBM may not charge, withhold, or recoup direct or indirect remuneration fees, dispensing fees, brand name or generic effective rate adjustments through reconciliation, or any other monetary charge, withholding, or recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when a fee may be recouped from a pharmacy. This prohibition does not apply to:
    - Any incentive payments provided by the PBM to a network pharmacy for meeting or exceeding predefined quality measures, recoupment due to an erroneous claim, fraud, waste, or abuse; a claim adjudicated in error; a maximum allowable cost appeal pricing adjustment; or an adjustment made as part of a pharmacy audit.
    - Any recoupment that is returned to the state for programs in ch. 409, F.S., or the state group insurance program.
- Unless otherwise prohibited by law, a PBM may not prohibit a pharmacy from:
    - Offering mail or delivery services on an opt-in basis at the sole discretion of the covered person.

  - Mailing or delivering a prescription drug to a covered person upon request.
  - Charging a shipping or handling fee to a covered person requesting a prescription drug be mailed or delivered if the pharmacy discloses to the covered person before the mailing or delivery the amount of the fee that will be charged and that the fee may not be reimbursable by the covered person's pharmacy benefits plan or program.
- The PBM must provide a reasonable administrative appeal procedure to allow a pharmacy to challenge the maximum allowable cost (MAC) pricing information and the reimbursement made under MAC for a specific drug as being below the acquisition cost available to the challenging pharmacy.
  - The pharmacy must be given at least 30 business days after an MAC update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal. The PBM must respond to the administrative appeal within 30 business days after receipt of the appeal.
  - If the appeal is upheld, the PBM must:
    - Update the MAC information to at least the acquisition cost available to the pharmacy;
    - Permit the pharmacy to reverse and rebill the claim in question;
    - Provide to the pharmacy or pharmacist the national drug code on which the increase or change is based; and
    - Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable MAC pricing information.
  - If the appeal is denied, the PBM must provide to the pharmacy or pharmacist the national drug code and the name of the national or regional pharmaceutical wholesalers operating in this state which have the drug currently in stock at a price below the MAC pricing information.
- Every 90 days, a PBM must report to the office the total number of appeals received and denied in the preceding 90-day period, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted.

Prohibited Acts by a PBM

Pursuant to s. 626.8827, F.S., a PBM may not engage in the following acts:

- Prohibit, restrict, or penalize in any way a pharmacy from disclosing to any person any information that the pharmacy deems appropriate, including information regarding any of the following:
  - The nature of treatment, risks, or alternatives.
  - The availability of alternate treatment, consultations, or tests.
  - The decision of utilization reviewers or similar persons to authorize or deny pharmacist services.
  - The process used to authorize or deny pharmacist services or benefits.
  - Information on financial incentives and structures used by the pharmacy benefits plan or program.
  - Information that may reduce the costs of pharmacist services.
  - Whether the cost-sharing obligation exceeds the retail price for a covered prescription drug and the availability of a more affordable alternative drug.
- Communicate at the point-of-sale, or require, a cost-sharing obligation for the covered person in an amount that exceeds the lesser of the applicable cost-sharing amount under the

applicable pharmacy benefits plan or program; or the usual and customary price, as defined in s. 626.8825, F.S., of the pharmacist services.
- Fail to comply with the requirements in s. 624.491, F.S., relating to pharmacy audits. or s. 626.8825, F.S., relating to PBM transparency and accountability provisions.

OIR Examinations and Investigations of PBMs

The OIR must examine the business and affairs of each PBM at least biennially. The scope of the examination is to determine the PBM's compliance with all provisions of part VII of ch. 626, F.S., and must include a detailed review of the PBM's compliance with ss. 626.8825 and 626.8827, F.S. In addition to any other enforcement authority available to the OIR, the OIR must impose an administrative fine of $5,000 for each violation of ss. 626.8825 or 626.8827, F.S.

State Group Insurance Program

Pursuant to s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance (DSGI), administers the State Group Insurance Program under a cafeteria plan consistent with s. 125 Internal Revenue Code. To administer the program, DSGI contracts with third party administrators for self-insured health plans, a fully insured HMO, and a PBM for the state employees' Self-Insured Prescription Drug Program (PDP) pursuant to s. 110.12315, F.S. The program currently provides health and pharmacy benefits to over 170,000 state employees, retirees, and their dependents. The current PBM for the state employees' prescription drug plan is OptumRx.[137] Under current law, there is no statutory minimum for the professional dispensing fee that a PBM must pay to a participating pharmacy. These fees are currently determined through contractual negotiations between the PBM and the pharmacies in its network, and between the PBM and DMS.[138]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 1.01, F.S., to create a definition for the term "Joint Legislative Committee on Medicaid Oversight" to specify a committee designated by joint rule of the Legislature, by the President of the Senate or the Speaker of the House of Representatives, or by agreement between the President of the Senate and the Speaker of the House of Representatives.

Section 2 creates s. 11.405, F.S., to establish the Joint Legislative Committee on Medicaid Oversight to ensure that the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

The bill requires that the committee be composed of five members of the Senate appointed by the President of the Senate and five members of the House of Representatives appointed by the Speaker of the House of Representatives, with each member serving a two-year term. The chair and vice chair must be appointed for one-year terms, with the appointments alternating between the President of the Senate and the Speaker of the House of Representatives. The chair and vice

[137] Department of Management Services, Division of State Group Insurance, available at: https://www.mybenefits.myflorida.com/myhealth/prescription_drug_plan (last visited Feb. 8, 2026).
[138] *Id.*

chair may not be members of the same house of the Legislature, and if both the chair and the vice chair are absent at any meeting, the members present must elect a temporary chair by a majority vote.

The bill requires that members serve without compensation, but authorizes reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S. The bill authorizes the chair to establish subcommittees as needed to fulfill committee duties. The bill also requires the committee to convene at least twice a year, and as often as necessary to conduct its business. Meetings may be held through teleconference or other electronic means.

The bill requires the committee to evaluate all aspects of the state Medicaid program related to program financing, quality of care and health outcomes, administrative functions, and operational functions to ensure the program is providing transparency in the provision of health care plans and providers, ensuring access to quality health care services to Medicaid recipients, and providing stability to the state's budget through a health care delivery system designed to contain costs.

The bill requires the committee to identify and recommend policies that limit Medicaid spending growth while improving health care outcomes for Medicaid recipients. In developing its recommendations, the committee must do the following:

- Evaluate legislation for its long-term impact on the state Medicaid program.
- Review data submitted to the AHCA by Medicaid managed care plans pursuant to statutory and contract requirements, including, but not limited to, timeliness of provider credentialing, timely payment of claims, rate of claim denials, prior authorization for services, and consumer complaints.
- Review the Medicaid managed care plans' encounter data, financials, and audits and the data used to calculate the plans' achieved savings rebates and medical loss ratios.
- Review data related to health outcomes of Medicaid recipients, including, but not limited to, Healthcare Effectiveness Data and Information Set measures for each Medicaid managed care plan, each Medicaid managed care plan's performance improvement projects, and outcome data related to all quality goals included in the Medicaid managed care organization contracts to improve quality for recipients.
- Identify any areas for improvement in statute and rule relating to the state Medicaid program.
- Develop a plan of action for the future of the state Medicaid program.

The bill authorizes the committee to submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

The bill requires the Auditor General and the AHCA to enter into and maintain a data sharing agreement by July 1, 2026, to ensure the committee has full access to all data needed to fulfill its responsibilities. The Auditor General must assist the committee in its work by providing credentialed professional staff or consulting services, including, but not limited to, an actuary not associated with the state Medicaid program or any Medicaid managed care organization who currently has a contract with the state.

The bill requires the committee to be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of the state, or any entity engaged in

business or under contract with a state agency during the course of its official duties. The committee may compel the attendance and testimony of any state official or employee before the committee or secure any evidence as provided in s. 11.143, F.S. The bill provides that the committee shall also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of the Senate and the House of Representatives applicable to joint legislative committees apply to the proceedings of the committee.

The bill requires the AHCA to notify the committee of any change to the Medicaid managed care capitation rates and to appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates before implementation of any change to the capitation rates. The report must include the AHCA's historical and projected Medicaid program expenditure and utilization trend rates by Medicaid program and service category for the rate year, an explanation of how the trend rates were calculated, and the policy decisions that were included in setting the capitation rates.

If the AHCA or any division within the AHCA is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the bill requires the AHCA to submit a copy of the report to the committee.

Section 3 amends SMMC law in s. 409.962, F.S., to provide the following definitions: "Affiliate," including the terms "affiliated with" and "affiliation," means a person, as construed in s. 1.01(3), F.S.,[139] who:

- Directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person, including parent and subsidiary entities; or
- Is deemed a "related party" according to the standards adopted by the Financial Accounting Standards Board.

"Control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership or voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

This definition of "control" applies under the bill regardless of whether such power is affirmative or negative or whether such power is actually used. Control is presumed to exist, but is not limited to, when any affiliate or person, as construed in s. 1.01(3), F.S.:[140]

- Directly or indirectly owns, controls, holds the power to vote, or holds proxies representing 10 percent or more of any class of the voting securities of any other person.
- Shares common ownership with any person, has an investor or is a holder of an ownership interest in any person, exercises control in any manner over the election of a majority of the directors or of individuals exercising similar functions of any person, has the power to

[139] Section 1.01(3), F.S., provides that the word "person" includes individuals, children, firms, associations, joint adventures, partnerships, estates, trusts, business trusts, syndicates, fiduciaries, corporations, and all other groups or combinations.
[140] *Id.*

exercise controlling influence over the management of any person, or serves as a working majority of the board of directors, managers, or the officers of a person, who is:
- A provider or a member of a provider group or group practice as defined in s. 456.053, F.S., under the managed care plan; or
- A person responsible for providing any pharmacy services, pharmaceuticals, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services under the managed care plan.

Section 4 amends s. 409.967, F.S., as to matters involving Medicaid managed care plan accountability.

Encounter Data Reporting and Analysis

The bill requires Medicaid managed care plans to provide encounter data on encounters for which payment was denied and encounters for which a provider was reimbursed by the plan on a capitated basis.

Under the bill, the AHCA's analysis of encounter data must be used to identify possible cases of overspending on administrative costs, payments by plans in excess of market rates, and potential managed care plan fraud, waste, and abuse. And, the bill requires the analysis to be used in SMMC managed care plan capitation rate-setting.

Third-Party Administrators

The bill requires that a contract between the AHCA and a Medicaid managed care plan must require that any third party administrative entity contracted by the plan must adhere to all pertinent requirements of the Medicaid program placed on the plan under the plan's contract with the AHCA.

Achieved Savings Rebates

The bill revises the Medicaid ASR to alter the amount of profit that a managed care plan may retain versus how much of such profit must be shared with the state. Under the bill, the ASR is calculated by determining pretax income as a percentage of revenues and applying the following income sharing ratios:
- One hundred percent of income up to and including three percent of revenue (as opposed to five percent as in current law) is to be retained by the plan.
- Thirty percent (as opposed to 50 percent as in current law) of income above that three percent mark and up to ten percent is to be retained by the plan with the other 70 percent refunded to the state and adjusted for the federal match percentage.
- One hundred percent of income above 10 percent of revenue must be refunded to the state and adjusted for the federal match percentage, which is the same as current law.

Payments by a plan to affiliated entities in excess of market rates are excluded as an allowable expense under the bill when the AHCA calculates a plan's ASR.

Medical Loss Ratios

The bill provides that if required by federal regulations, the AHCA must calculate MLRs for all plans contracted under the SMMC program, including managed medical assistance, long-term care managed care, and the pilot program for individuals with developmental disabilities. The bill requires MLRs to be calculated for a managed care plan separately for each SMMC component in which the plan participates and for the plan's overall participation in SMMC. The AHCA must calculate such MLRs quarterly and annually and report to the Governor and the Legislature no later than six months after the end of each such period.

The bill also corrects the current reference in s. 409.967(4)(a), F.S., to certain federal MLR regulations so that federal regulations found in 42 C.F.R. part 438 are referenced relating to federal MLR requirements for Medicaid managed care plans.

The bill deletes current law's provisions designed to allow managed care plans to donate funds to graduate medical education programs or indigent care and have those dollar amounts count as medical expenses in the MLR calculations. Those provisions were not approved by CMS in Florida's SMMC waiver.

Affiliated Entities and Related Parties; Managed Care Plan Capitations

The AHCA is directed under the bill to ensure oversight of affiliated entities and related parties paid by managed care plans, including, but not limited to, examining financial records and self-referral data of any managed care plan providing services within SMMC which uses affiliated entities and related parties. The AHCA is also directed under the bill to consider data examined under such requirement and the findings of the annual assessment required under s. 409.9675(4), F.S., (see below) when developing SMMC managed care plan capitation rates.

Section 5 creates s. 409.9675, F.S., concerning affiliated entities and controlling interest reporting by Medicaid managed care plans. Each managed care plan is required under the bill to report to the AHCA and the OIR the following:

- Any person controlled or affiliated with the managed care plan; and
- Any person who has an ownership interest of ten percent or greater in an affiliate or controlled entity.

The disclosure obligation concerns direct and indirect relationships. The list of affiliated or controlled entities includes any provider, group practice, pharmacy service, pharmaceutical, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative or financial services to the managed care entity. The reporting is to commence March 31, 2027 and continue each year thereafter.

The contents of such annual report must contain the following information, as to any affiliations reported:

- Percentage of ownership or control of any person or entity who has any business transaction with the managed care plan in the aggregate of $25,000 or more for the preceding twelve months. The identification of such business transaction must include the specific contracts involved.

- Any significant business transaction between the managed care plan and affiliated entity, during the preceding twelve months.

If there is a change in the reported data, such change must be reported to the AHCA and the OIR within 60 days of occurrence under the bill.

Affiliation information is to be assessed and publicly reported annually by the AHCA commencing December 31, 2026. The report is to include an assessment as to how affiliate payments impact the medical benefits and administrative cost for the ASR. The initial assessment is to use years 2021, 2022, and 2023 as baseline years. The assessment report must include information which shows the amount of affiliated entity payments within the MLR, how payments for affiliated entities compare to nonaffiliated entities, and payment amounts for value-based or alternative payment arrangements.

Section 6 amends s. 626.8825, F.S., relating to PBM transparency and accountability. The section defines the term, "affiliated manufacturer," to mean a prescription drug manufacturer permitted under part I of ch. 499,F.S., or an entity that contracts with a prescription drug manufacturer or nonresident prescription drug manufacturer permitted under part I of ch. 499, F.S., or an affiliate thereof for the promotion and marketing of prescription drugs, which prescription drug manufacturer or contracting entity directly or indirectly through one or more intermediaries:

- Has an investment or ownership interest in a pharmacy benefit manager holding a certificate of authority issued under this part;
- Shares common ownership with a pharmacy benefit manager holding a certificate of authority issued under this part; or
- Has an investor or a holder of an ownership interest which is a pharmacy benefit manager holding a certificate of authority issued under this part.

The bill also revises requirements that a PBM may impose on a specialty network participation, relating to drug safety, by removing references to provider coordination, clinical care, and monitoring since they are required to meet drug safety standards related to meeting FDA limited distribution requirements for dispensing drugs. Further, the bill prohibits a PBM from denying a pharmacy participation in a specialty network if the pharmacy can demonstrate the pharmacy's ability to dispense a drug in accordance with the FDA's approved manufacturer labeling.

The bill also clarifies that a PBM may not offset or recoup any renumeration fees, dispensing fees, brand name or generic effective rate adjustments, recoupments or other adjustments from a pharmacy if such action would reduce the amount paid to the pharmacy.

The bill revises the administrative appeal process for contesting the maximum allowable cost (MAC) pricing information and the reimbursement made for a specific drug by allowing a pharmacy or pharmacist the option to submit an electronic spreadsheet containing a consolidated administrative appeal representing multiple adjudicated claims that share the same drug and day supply, and have a date of service occurring within the same calendar month.

The bill revises the deadline for PBMs to submit quarterly reports to Office of Insurance Regulation (OIR) relating to MAC appeals to provide the deadlines are March 1 for the

preceding year′s 4th quarter; May 15 for each year′s first quarter; August 15 for each year′s second quarter; and November 15 for each year′s third quarter. Currently such reports are due every 90 days for the preceding 90 days.

Section 7 amends s. 626.8825, F.S., relating to PBM prohibited practices, to provide that a breach of contractual terms required under s. 626.8825, F.S., is a prohibited practice. Further, the bill provides that a PBM may not reimburse a pharmacy or pharmacist a minimum dispensing fee of no less than $10.24, which is the current Medicaid fee-for-service minimum dispensing fee for outpatient prescription drugs. Further, the bill requires that such fee must be automatically adjusted every January 1 in an amount equal to the average percentage change in the Consumer Price Index (CPI) for medical care for all urban consumers over the immediately preceding 12-month period. The OIR is authorized to revise the minimum dispensing fee upon reasonably determining that the current fee provides excessive or inadequate payments to pharmacies when compared to payments made in other states. However, any adjustment by OIR may not result in a dispensing fee that is less than the current Medicaid fee-for-service minimum dispensing fee. Currently, such dispensing fees are negotiated between a pharmacy and a PBM.

The bill prohibits a PBM from restricting a pharmacy from declining to dispense a drug if the reimbursement rate for the drug is less than the actual acquisition cost to the pharmacy. The bill also prohibits a PBM from reimbursing a pharmacy less than it reimburses an affiliate pharmacy.

Lastly, the bill prohibits a PBM from maintaining an ownership interest, investment interest, or common ownership with an affiliated manufacturer, or share any investor or holder of an ownership interest with an affiliated manufacturer.

Section 8 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:

Impairment of Contracts

Both the U.S. and Florida Constitutions prohibit laws that substantially impair existing contractual obligations. Florida courts apply a three-part test examining whether the law: (1) substantially impairs a contractual relationship; (2) serves a significant and legitimate public purpose; and (3) employs means reasonably necessary to achieve that purpose.

SB 1760's mandate to increase dispensing fees to $10.24 and prohibiting PBM affiliations with manufacturers would materially alter the financial and structural terms of existing multiyear contracts between DMS and PBM vendors. If applied to contracts executed before July 1, 2026, these provisions are likely to constitute a "substantial impairment," as they increase mandatory payouts and restrict corporate structure mid contract. The Florida Supreme Court held in *Dewberry v. Auto-Owners Ins. Co.,* that legislation diminishing the value of an existing contract, such as by increasing required payments may violate the Contracts Clause. Absent a clear prospective application, these provisions face an elevated risk of being found unconstitutional as applied to existing state contracts.

Equal Protection and Structural Divestiture
SB 1760's prohibition on PBMs owning or investing in "affiliated manufacturers" targets a specific vertical integration model and may be challenged under the Equal Protection Clause. Similar prohibitions are being attempted in Arkansas and are being challenged as a "Bill of Attainder" because they allegedly targeted three specific national PBM's for "punishment "forced divestiture" without trial.[141] If Florida cannot demonstrate that manufacturer affiliation uniquely causes public harm, distinct from other forms of vertical integration such as PBM pharmacy or PBM insurer relationships; the provision may be vulnerable to claims that it is arbitrary and unconstitutional.

Dormant Commerce Clause and Protectionism
The bill's $10.24 dispensing fee floor and out-of-network parity requirements may be characterized as protectionist measures favoring local, independent pharmacies at the expense of national, out-of-state PBMs and manufacturers. Under the Dormant Commerce Clause, states may not enact laws that discriminate against or unduly burden interstate commerce to confer a competitive advantage on local industry.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Medicaid Managed Care Plans

[141] On July 28, 2025, Judge Brian Miller of the U.S. District Court for the Eastern District of Arkansas granted a preliminary injunction preventing the law from taking effect because it likely violates the Commerce Clause of the U.S. Constitution, and is likely preempted by TRICARE. Express Scripts Inc et al v. Richmond et al, No. 4:2025cv00520 - Document 73 (E.D. Ark. 2025), available at: https://law.justia.com/cases/federal/district-courts/arkansas/aredce/4:2025cv00520/147864/73/ (last visited Feb. 10, 2026).

The AHCA reports that if the revisions to ASR profit-sharing percentages in section 4 of the bill had been in effect in 2024 (the most recent calendar year for which ASRs have been finalized), Medicaid managed care plans would have been required to return approximately $128.3 million more in profit to the state for that year, in addition to the $51.3 million that was returned for 2024 under current law.[142] The overall impact of such an outcome on plan solvency, if that portion of the bill were to take effect prospectively, is not known.

Medicaid managed care plans may also be negatively impacted by the bill's requirements for payments made by the plans in excess of "market rates" to be considered in the capitation rate-setting process and to be excluded from ASR calculations.

Health Insurers, HMOs, Pharmacies, and Consumers of Health Coverage
The mandated minimum pharmacy dispensing fee under section 7 of the bill will have a significant negative fiscal impact on health insurers and managed care plans and, ultimately, employers and insureds, based on the estimates provided by State Group Insurance and Medicaid. Conversely, pharmacies will significantly benefit from the mandated dispensing fees.

Section 7 of the bill also allows a pharmacy to refuse to fill a prescription if the reimbursement is less than the acquisition cost of the drug, regardless of other contractual terms involved in such reimbursement. This may result in network adequacy issues for health insurers and managed care plans, particularly in rural and medically underserved communities, where independent pharmacies can be the sole provider of medication counseling and management, as well as the main source for immunizations and rescue medications like EpiPens for allergic reactions.[143].

C. Government Sector Impact:

Medicaid
As mentioned under "Private Sector Impact," the AHCA has provided the following estimate of additional rebate dollars the state would collect as a result of the changes to the Medicaid ASR percentages under the bill. An AHCA analysis of 2024 data indicates that, in addition to the $51.3 million of profit that was returned to Florida Medicaid for that calendar year, an additional amount of approximately $128.3 million of managed care plan profit would also have been returned by the plans, in the aggregate, if the bill's ASR revisions had been in effect in 2024.[144] The federal share of those additional refunds would have been returned to the federal government, consistent with the federal Medicaid match percentage.

SB 1760's pharmacy dispensing fee mandate will significantly increase costs to the state Medicaid program. The anticipated negative fiscal impact to Medicaid from the

[142] Agency for Health Care Administration, *SB 1760 Legislative Bill Analysis,* (Jan. 13, 2026) (on file with the Senate Committee on Health Policy).
[143] Federal Trade Commission, Office of Policy Planning, *supra* note 108.
[144] Agency for Health Care Administration, *supra* note 142.

dispensing fee mandate is approximately $227.3 million, increasing annually on a recurring basis in accordance with the CPI for medical care.[145]

State Group Health Insurance
SB 1760 will have a significant and ongoing negative fiscal impact to the State Employees Health Insurance Trust Fund due to the mandated pharmacy dispensing fee. The bill will increase costs to the trust fund by $45.4 million initially and will likely increase annually thereafter because of the CPI adjustment requirement.[146]

VI. Technical Deficiencies:

On lines 156-159, the bill requires the auditor general and the AHCA to have entered into a data sharing agreement by July 1, 2026, which is the same date that the requirement takes effect since the bill's effective date is also July 1, 2026.

VII. Related Issues:

Portions of the bill address Medicaid managed care plan capitation rate-setting and the calculation of each plan's ASR. The bill requires the AHCA to include in such rate-setting and calculations a plan's payments that may be in excess of "market rates." However, the bill does not provide a definition of "market rate."

The current Medicaid managed care plan ASR statutes require the AHCA to calculate each plan's ASR on a calendar-year basis. The bill changes the ASR percentages for profit-sharing effective July 1, 2026. It may be advisable to make the bill's ASR percentage revisions effective January 1, 2027, to avoid requiring the AHCA to attempt to apply new percentages halfway through the 2026 reporting cycle.

The bill's revisions to PBM statutes may be preempted relating to Medicare Part D plans and their PBMs under the federal "standards" clause, found in 42 U.S.C. § 1395w-26(b)(3), to the extent the bill seeks to regulate pharmacy reimbursement methodologies, dispensing fees, or network parity already governed by CMS for such plans.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 1.01, 409.962, 409.967, 626.8825, and 626.8827.

This bill creates the following sections of the Florida Statutes: 11.405 and 409.9675.

[145] *Id.*
[146] Department of Management Services, *SB 1760 Legislative Bill Analysis,* (Jan. 28, 2026) (on file with the Senate Committee on Health Policy).

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.

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LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Effective upon this act becoming a law, subsection (20) is added to section 1.01, Florida Statutes, to read:

1.01 Definitions.—In construing these statutes and each and every word, phrase, or part hereof, where the context will permit:

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(20) The term "Joint Legislative Committee on Medicaid Oversight" means a committee or committees designated by joint rule of the Legislature, by the President of the Senate or the Speaker of the House of Representatives, or by agreement between the President of the Senate and the Speaker of the House of Representatives.

Section 2. Effective upon this act becoming a law, section 11.405, Florida Statutes, is created to read:

11.405 Joint Legislative Committee on Medicaid Oversight.—The Joint Legislative Committee on Medicaid Oversight is created to ensure that the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

(1) MEMBERSHIP; SUBCOMMITTEES; MEETINGS.—

(a) The committee shall be composed of five members of the Senate appointed by the President of the Senate and five members of the House of Representatives appointed by the Speaker of the House of Representatives, with each member serving a 2-year term. The chair and vice chair shall each be appointed for 1-year terms, with the appointments alternating between the President of the Senate and the Speaker of the House of Representatives. The chair and vice chair may not be members of the same house of the Legislature. If both the chair and vice chair are absent at any meeting, the members present must elect a temporary chair by a majority vote.

(b) Members shall serve without compensation but may be reimbursed for per diem and travel expenses pursuant to s. 112.061.

(c) The chair may establish subcommittees as needed to

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fulfill the committee's duties.

(d) The committee shall convene at least twice a year, and as often as necessary to conduct its business as required under this section. Meetings may be held through teleconference or other electronic means.

(2) COMMITTEE DUTIES.—

(a) The committee shall evaluate all aspects of the state Medicaid program related to program financing, quality of care and health outcomes, administrative functions, and operational functions to ensure that the program is providing transparency in the provision of health care plans and providers, ensuring Medicaid recipients have access to quality health care services and providing stability to the state's budget through a health care delivery system designed to contain costs.

(b) The committee shall identify and recommend policies that limit Medicaid spending growth while improving health care outcomes for Medicaid recipients. In developing its recommendations, the committee shall do all of the following:

1. Evaluate legislation for its long-term impact on the state Medicaid program.

2. Review data submitted to the Agency for Health Care Administration by the Medicaid managed care plans pursuant to statutory and contract requirements, including, but not limited to, timeliness of provider credentialing, timely payment of claims, rate of claim denials, prior authorizations for services, and consumer complaints.

3. Review the Medicaid managed care plans' encounter data, financial data, and audits and the data used to calculate the plans' achieved savings rebates and medical loss ratios.

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4. Review data related to health outcomes of Medicaid recipients, including, but not limited to, Healthcare Effectiveness Data and Information Set measures developed by the National Committee for Quality Assurance, for each Medicaid managed care plan, each Medicaid managed care plan's performance improvement projects, and outcome data related to all quality goals included in the Medicaid managed care organization contracts to improve quality for recipients.

5. Identify any areas for improvement in statute and rule relating to the state Medicaid program.

6. Develop a plan of action for the future of the state Medicaid program.

(c) The committee may submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

(3) COOPERATION.—

(a) The Auditor General and the Agency for Health Care Administration shall enter into and maintain a data sharing agreement by July 1, 2026, to ensure the committee has full access to all data needed to fulfill its responsibilities.

(b) The Auditor General shall assist the committee in its work by providing credentialed professional staff or consulting services, including, but not limited to, an actuary not associated with the state Medicaid program or any Medicaid managed care organization who currently has a contract with the state.

(c) The committee, in the course of its official duties, must be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of

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the state, or any entity engaged in business or under contract with a state agency, and may compel the attendance and testimony of any state official or employee before the committee or secure any evidence as provided in s. 11.143. The committee may also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of the Senate and the House of Representatives applicable to joint legislative committees apply to the proceedings of the committee under this section.

(4) AGENCY REPORTS.—

(a) Before implementing any change to the Medicaid managed care capitation rates, the Agency for Health Care Administration shall notify the committee of the change and appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates. The report must include the agency's historical and projected Medicaid program expenditure and utilization trend rates by Medicaid program and service category for the rate year, an explanation of how the trend rates were calculated, and the policy decisions that were included in setting the capitation rates.

(b) If the Agency for Health Care Administration or any division within the agency is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the agency must also submit a copy of the report to the committee.

Section 3. Present subsections (2) through (5), (6) through (10), and (11) through (18) of section 409.962, Florida Statutes, are redesignated as subsections (3) through (6), (8)

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through (12), and (14) through (21), respectively, and new subsections (2), (7), and (13) are added to that section, to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(2) "Affiliate," including the terms "affiliated with" and "affiliation," means a person, as construed in s. 1.01(3), who:

(a) Directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person, including parent and subsidiary entities; or

(b) Is deemed a "related party" according to the standards adopted by the Financial Accounting Standards Board.

(7) "Control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership or voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. This definition applies regardless of whether such power is affirmative or negative or whether such power is actually used. Control is presumed to exist, but is not limited to, when any affiliate or person, as construed in s. 1.01(3):

(a) Directly or indirectly owns, controls, holds the power to vote, or holds proxies representing 10 percent or more of any class of the voting securities of any other person.

(b) Shares common ownership with any person; has an

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investor or is a holder of an ownership interest in any person; exercises control in any manner over the election of a majority of the directors or of individuals exercising similar functions of any person; has the power to exercise controlling influence over the management of any person; or serves as a working majority of the board of directors, the managers, or the officers of a person, who is:

1. A provider or a member of a provider group or group practice as defined in s. 456.053(3) under the managed care plan; or

2. A person responsible for providing any pharmacy services, pharmaceuticals, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services under the managed care plan.

(13) "Market rate" means the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction which is beneficial to both parties.

Section 4. Subsections (1) and (2), paragraph (h) of subsection (3), and subsection (4) of section 409.967, Florida Statutes, are amended, and subsection (5) is added to that section, to read:

409.967 Managed care plan accountability.—

(1) CONTRACT PROCUREMENT PROCESS.—Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to

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cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

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

(a) *Physician compensation.*—Managed care plans are expected to coordinate care, manage chronic disease, and prevent the need for more costly services. Effective care management should enable plans to redirect available resources and increase compensation for physicians. Plans achieve this performance standard when physician payment rates equal or exceed Medicare rates for similar services. The agency may impose fines or other sanctions on a plan that fails to meet this performance standard after 2 years of continuous operation.

(b) *Emergency services.*—Managed care plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider. The plans must comply with s. 641.3155. Reimbursement for services under this paragraph is the lesser of:

1. The provider’s charges;

2. The usual and customary provider charges for similar services in the community where the services were provided;

3. The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

4. The Medicaid rate, which, for the purposes of this

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paragraph, means the amount the provider would collect from the agency on a fee-for-service basis, less any amounts for the indirect costs of medical education and the direct costs of graduate medical education that are otherwise included in the agency's fee-for-service payment, as required under 42 U.S.C. s. 1396u-2(b)(2)(D). For the purpose of establishing the amounts specified in this subparagraph, the agency shall publish on its website annually, or more frequently as needed, the applicable fee-for-service fee schedules and their effective dates, less any amounts for indirect costs of medical education and direct costs of graduate medical education that are otherwise included in the agency's fee-for-service payments.

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both

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the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

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

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

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

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

(d) *Quality care.*—Managed care plans shall provide, or contract for the provision of, care coordination to facilitate the appropriate delivery of behavioral health care services in the least restrictive setting with treatment and recovery capabilities that address the needs of the patient. Services shall be provided in a manner that integrates behavioral health services and primary care. Plans shall be required to achieve specific behavioral health outcome standards, established by the agency in consultation with the department.

(e) *Encounter data.*—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's

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reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data, including data on encounters for which payment was denied and encounters for which a health care provider was reimbursed by the plan on a capitated basis, electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of overspending on administrative costs, payments by plans in excess of market rates, systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters, and potential managed care plan fraud, waste, and abuse. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs. The analysis shall be used in managed care plan capitation rate-setting processes provided under this part.

3. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

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4. The agency shall annually produce a report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees." The report must include, but need not be limited to, an analysis of the potentially preventable hospital emergency department visits, hospital admissions, and hospital readmissions that occurred during the previous state fiscal year which may have been prevented with better access to primary care, improved medication management, or better coordination of care, reported by age, eligibility group, managed care plan, and region, including conditions contributing to each potentially preventable event or category of potentially preventable events. The agency may include any other data or analysis parameters to augment the report which it deems pertinent to the analysis. The report must demonstrate trends using applicable historical data. The agency shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The agency may contract with a third-party vendor to produce the report required under this subparagraph.

(f) *Continuous improvement.*—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

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2. Each managed care plan must collect and report the Healthcare Effectiveness Data and Information Set (HEDIS) measures, the federal Core Set of Children's Health Care Quality measures, and the federal Core Set of Adult Health Care Quality Measures, as specified by the agency. Each plan must collect and report the Adult Core Set behavioral health measures beginning with data reports for the 2025 calendar year. Each plan must stratify reported measures by age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income beginning with data reports for the 2026 calendar year. A plan's performance on these measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under ss. 409.977 and 409.984.

(g) *Program integrity.*—Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

1. A provider credentialing system and ongoing provider monitoring, including maintenance of written provider credentialing policies and procedures which comply with federal

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and agency guidelines;

2. An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

3. Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

4. Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

5. Designation of a program integrity compliance officer.

(h) *Grievance resolution.*—Consistent with federal law, each managed care plan shall establish and the agency shall approve an internal process for reviewing and responding to grievances from enrollees. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees.

(i) *Penalties.*—

1. Withdrawal and enrollment reduction.—Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the agency for the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per-enrollee penalty of up to 3 months' payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other departing plans must pay a penalty of 25 percent of that

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portion of the minimum surplus maintained pursuant to s. 641.225(1) which is attributable to the provision of coverage to Medicaid enrollees. Plans shall provide at least 180 days' notice to the agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the agency shall terminate all contracts with that plan in other regions pursuant to the termination procedures in subparagraph 3.

2. Encounter data.—If a plan fails to comply with the encounter data reporting requirements of this section for 30 days, the agency must assess a fine of $5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

3. Termination.—If the agency terminates more than one regional contract with the same managed care plan due to noncompliance with the requirements of this section, the agency shall terminate all the regional contracts held by that plan. When terminating multiple contracts, the agency must develop a plan to provide for the transition of enrollees to other plans, and phase in the terminations over a time period sufficient to ensure a smooth transition.

(j) *Prompt payment.*—Managed care plans shall comply with ss. 641.315, 641.3155, and 641.513.

(k) *Electronic claims.*—Managed care plans, and their fiscal agents or intermediaries, shall accept electronic claims in compliance with federal standards.

(l) *Fair payment.*—Provider service networks must ensure

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that no entity licensed under chapter 395 with a controlling interest in the network charges a Medicaid managed care plan more than the amount paid to that provider by the provider service network for the same service.

(m) *Itemized payment.*—Any claims payment to a provider by a managed care plan, or by a fiscal agent or intermediary of the plan, must be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is made.

(n) *Provider dispute resolution.*—Disputes between a plan and a provider may be resolved as described in s. 408.7057.

(o) *Transparency.*—Managed care plans shall comply with ss. 627.6385(3) and 641.54(7).

(p) *Third-party administrators.*—The agency's contract with a managed care plan must require that any third-party administrative entity contracted by the plan adheres to all pertinent requirements of the Medicaid program placed on the plan under the plan's contract with the agency.

(3) ACHIEVED SAVINGS REBATE.—

(h) The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:

1. Payment of achieved savings rebates.

2. Any financial incentive payments made to the plan outside of the capitation rate.

3. Any financial disincentive payments levied by the state or Federal Government.

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4. Expenses associated with any lobbying or political activities.

5. The cash value or equivalent cash value of bonuses of any type paid or awarded to the plan's executive staff, other than base salary.

6. Reserves and reserve accounts.

7. Administrative costs, including, but not limited to, reinsurance expenses, interest payments, depreciation expenses, bad debt expenses, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the agency.

8. Payments to affiliates as defined in s. 409.962 in excess of market rates.

The agency shall consider these and other factors in developing contracts that establish shared savings arrangements.

(4) MEDICAL LOSS RATIOS ~~RATIO~~.—

(a) If required by federal regulations or as a condition of a waiver, the agency must ~~may~~ calculate ~~a~~ medical loss ratios ~~ratio~~ for all managed care plans contracted with the agency under this part. The calculations must ~~calculation shall~~ use uniform financial data collected from all plans ~~and shall be computed for each plan on a statewide basis~~. If a plan participates in the managed medical assistance program, the long-term care managed care program, or the pilot program for individuals with developmental disabilities, the agency must calculate medical loss ratios for the plan's participation in each program separately and, if the plan participates in more than one of these programs, for the plan's overall participation in statewide Medicaid managed care. Medical loss ratios must be

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calculated and ~~The method for calculating the medical loss ratio shall meet the following criteria:~~

~~(a) Except as provided in paragraphs (b) and (c),~~ expenditures must ~~shall~~ be classified in a manner consistent with 42 C.F.R. part 438 ~~45 C.F.R. part 158~~.

(b) The agency shall report medical loss ratios quarterly and annually for each managed care plan contracted with the agency under this part to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than 6 months after the end of each such period ~~Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.~~

~~(c) Before final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period. Funds contributed for this purpose shall be deposited into the Grants and Donations Trust Fund~~.

(5) AFFILIATED ENTITIES AND RELATED PARTIES.—

(a) The agency shall ensure oversight of affiliated entities and related parties paid by managed care plans under this part, including, but not limited to, examining financial records and self-referral data of any managed care plan providing services within the statewide managed care program

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which uses affiliated entities and related parties.

(b) The agency shall consider data examined under paragraph (a) and the findings of the annual assessment required under s. 409.9675(4) when developing managed care plan capitation rates under this part.

Section 5. Effective January 1, 2027, paragraph (f) of subsection (3) of section 409.967, Florida Statutes, is amended, and paragraph (g) of that subsection is republished, to read:

409.967 Managed care plan accountability.—

(3) ACHIEVED SAVINGS REBATE.—

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 3 ~~5~~ percent of revenue shall be retained by the plan.

2. Thirty ~~Fifty~~ percent of income above 3 ~~5~~ percent and up to 10 percent shall be retained by the plan, and the other 70 ~~50~~ percent shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the

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federal share shall be transferred to the Medical Care Trust Fund, unallocated.

(g) A plan that exceeds agency-defined quality measures in the reporting period may retain an additional 1 percent of revenue. For the purpose of this paragraph, the quality measures must include plan performance for preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

Section 6. Section 409.9675, Florida Statutes, is created to read:

409.9675 Affiliated entities and controlling interests; reports required.—

(1) Each managed care plan contracted by the agency under this part shall report all of the following by March 31, 2027, for the prior calendar year, and annually thereafter, to the agency and the Office of Insurance Regulation in a manner prescribed by the agency:

(a) Any person controlled by or affiliated with the managed care plan, including, but not limited to, any provider, provider group, group practice defined in s. 456.053(3), or person responsible for providing any pharmacy services, pharmaceuticals, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services for, to, or on behalf of the managed care plan.

(b) Any affiliation of any kind or nature with any person which has, either directly or indirectly through one or more intermediaries, an investment or ownership interest representing 10 percent or more, shares common ownership with, or has an

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investor or a holder of an ownership interest representing 10 percent or more with any person providing pharmacy services, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services for, to, or on behalf of the managed care plan.

(2) For any affiliation reported by a managed care plan under subsection (1), the report must include all of the following:

(a) The percentage of ownership or control of any person or affiliate with whom the managed care plan has had business transactions totaling in the aggregate more than $25,000 during the prior 12-month period in the annual achieved savings rebate financial reporting required under s. 409.967(3) and identification of the specific contract or contracts involved in such business transactions.

(b) Any significant business transactions between the managed care plan and any affiliated person during the 12-month period in the annual achieved savings rebate financial reporting required under s. 409.967(3).

(3) Each managed care plan shall report any change in information required by subsection (1) to the agency and the Office of Insurance Regulation in writing within 60 days after the change occurs.

(4) By December 31, 2026, and annually thereafter, the agency shall calculate, analyze, and publicly report on the agency’s website an assessment of affiliated entity payment transactions in the Medicaid program for medical benefit and administrative costs as reported for purposes of the achieved

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savings rebate. The baseline assessment, at a minimum, must include achieved savings rebate transactions for the years 2021, 2022, and 2023; the amount and associated percentage of affiliated entity payments within the medical loss ratio; and the payment deviation percentages and associated amounts at the Healthcare Common Procedure Coding System level for affiliated entities as compared to nonaffiliated entities. The assessment must also compare payment amounts for value-based or alternative payment arrangements.

Section 7. Present paragraphs (b), (c), and (d), and (e) through (x) of subsection (1) of section 626.8825, Florida Statutes, are redesignated as paragraphs (c), (d), and (e), and (g) through (z), respectively, new paragraphs (b) and (f) are added to that subsection, and present paragraph (u) of subsection (1), paragraphs (e) and (g) of subsection (2), and paragraphs (c) and (h) of subsection (3) of that section are amended, to read:

626.8825 Pharmacy benefit manager transparency and accountability.—

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

(b) "Affiliated manufacturer" means a prescription drug manufacturer permitted under chapter 499 or a private label distributor as defined in 21 C.F.R. s. 207.1 which directly or indirectly through one or more intermediaries:

1. Has an investment or ownership interest in a pharmacy benefit manager holding a certificate of authority issued under this part;

2. Shares common ownership with a pharmacy benefit manager holding a certificate of authority issued under this part; or

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3. Has an investor or a holder of an ownership interest which is a pharmacy benefit manager holding a certificate of authority issued under this part.

(f) "Covered prescription drug" means any drug or biologic included in a pharmacy benefit manager's formulary which is paid for as a pharmacy benefit under the plan at any of the plan's network pharmacies.

(w) ~~(u)~~ "Pharmacy benefits plan or program" means a plan or program that pays for, reimburses, covers the cost of, or provides access to discounts on pharmacist services provided by one or more pharmacies to covered persons who reside in, are employed by, or receive pharmacist services from this state.

1. The term includes, but is not limited to, health maintenance organizations, health insurers, self-insured employer health plans, discount card programs, and government-funded health plans, including the Statewide Medicaid Managed Care program established pursuant to part IV of chapter 409 and the state group insurance program pursuant to part I of chapter 110.

2. The term excludes such a plan or program under s. 430.84 or chapter 440.

(2) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A PHARMACY BENEFITS PLAN OR PROGRAM.—In addition to any other requirements in the Florida Insurance Code, all contractual arrangements executed, amended, adjusted, or renewed on or after July 1, 2023, which are applicable to pharmacy benefits covered on or after January 1, 2024, between a pharmacy benefit manager and a pharmacy benefits plan or program must include, in substantial form, terms that ensure compliance with all of the

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following requirements and that, except to the extent not allowed by law, shall supersede any contractual terms to the contrary:

(e) Include network adequacy requirements that meet or exceed Medicare Part D program standards for convenient access to the network pharmacies set forth in 42 C.F.R. s. 423.120(a)(1) and that:

1. Do not limit a network to solely include affiliated pharmacies;

2. Require a pharmacy benefit manager to offer a provider contract to licensed pharmacies physically located on the physical site of providers that are:

a. Within the pharmacy benefits plan's or program's geographic service area and that have been specifically designated as essential providers by the Agency for Health Care Administration pursuant to s. 409.975(1)(a);

b. Designated as cancer centers of excellence under s. 381.925, regardless of the pharmacy benefits plan's or program's geographic service area;

c. Organ transplant hospitals, regardless of the pharmacy benefits plan's or program's geographic service area;

d. Hospitals licensed as specialty children's hospitals as defined in s. 395.002; or

e. Regional perinatal intensive care centers as defined in s. 383.16(2), regardless of the pharmacy benefits plan's or program's geographic service area.

Such provider contracts must be solely for the administration and ~~or~~ dispensing of covered prescription drugs~~, including~~

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~~biological products, which are administered through infusions, intravenously injected, or inhaled during a surgical procedure or are covered parenteral drugs,~~ as part of ~~onsite~~ outpatient care;

3. Do not require a covered person to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the pharmacy benefit manager's network for the covered person's pharmacy benefits plan or program. This subparagraph does not prohibit a pharmacy benefit manager from operating mail order or delivery programs on an opt-in basis at the sole discretion of a covered person, provided that the covered person is not penalized through the imposition of any additional retail cost-sharing obligations or a lower allowed-quantity limit for choosing not to select the mail order or delivery programs;

4. For the in-person administration of covered prescription drugs, prohibit requiring a covered person to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider; and

5. Prohibit offering or implementing pharmacy networks that require or provide a promotional item or an incentive, defined as anything other than a reduced cost-sharing amount or enhanced quantity limit allowed under the benefit design for a covered drug, to a covered person to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs; or advertising, marketing, or promoting an affiliated pharmacy to covered persons. Subject to

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the foregoing, a pharmacy benefit manager may include an affiliated pharmacy in communications to covered persons regarding network pharmacies and prices, provided that the pharmacy benefit manager includes information, such as links to all nonaffiliated network pharmacies, in such communications and that the information provided is accurate and of equal prominence. This subparagraph may not be construed to prohibit a pharmacy benefit manager from entering into an agreement with an affiliated pharmacy to provide pharmacist services to covered persons.

(g) Prohibit a pharmacy benefit manager from instituting a network that requires a pharmacy to meet accreditation standards inconsistent with or more stringent than applicable federal and state requirements for licensure and operation as a pharmacy in this state. However, a pharmacy benefit manager may specify additional specialty networks that require enhanced standards related to the safety and competency necessary to meet the United States Food and Drug Administration's limited distribution requirements for dispensing any drug that, on a drug-by-drug basis, requires extraordinary special handling~~, provider coordination, or clinical care or monitoring~~ when such extraordinary requirements cannot be met by a retail pharmacy. For purposes of this paragraph, drugs requiring extraordinary special handling are limited to drugs that are subject to a risk evaluation and mitigation strategy approved by the United States Food and Drug Administration and that:

1. Require special certification of a health care provider to prescribe, receive, dispense, or administer; or

2. Require special handling due to the molecular complexity

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or cytotoxic properties of the biologic or biosimilar product or drug.

For participation in a specialty network, a pharmacy benefit manager may not require a pharmacy to meet requirements for participation beyond those necessary to demonstrate the pharmacy's ability to dispense the drug in accordance with the United States Food and Drug Administration's approved manufacturer labeling.

(3) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A PARTICIPATING PHARMACY.—In addition to other requirements in the Florida Insurance Code, a participation contract executed, amended, adjusted, or renewed on or after July 1, 2023, that applies to pharmacist services on or after January 1, 2024, between a pharmacy benefit manager and one or more pharmacies or pharmacists, must include, in substantial form, terms that ensure compliance with all of the following requirements, and that, except to the extent not allowed by law, shall supersede any contractual terms in the participation contract to the contrary:

(c) A prohibition of financial clawbacks, reconciliation offsets, or offsets to adjudicated claims. A pharmacy benefit manager may not charge, withhold, offset, or recoup any direct or indirect remuneration fees, dispensing fees, brand name or generic effective rate adjustments through reconciliation, or any other monetary charge, withholding, or recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when an amount ~~a fee~~ may be recouped from a pharmacy if such action

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would result in a reduction in the amount paid to the pharmacy or pharmacist. This prohibition does not apply to:

1. Any incentive payments provided by the pharmacy benefit manager to a network pharmacy for meeting or exceeding predefined quality measures, such as Healthcare Effectiveness Data and Information Set measures; recoupment due to an erroneous claim, fraud, waste, or abuse; a claim adjudicated in error; a maximum allowable cost appeal pricing adjustment; or an adjustment made as part of a pharmacy audit pursuant to s. 624.491.

2. Any recoupment that is returned to the state for programs in chapter 409 or the state group insurance program in s. 110.123.

(h) The pharmacy benefit manager shall provide a reasonable administrative appeal procedure to allow a pharmacy or pharmacist to challenge the maximum allowable cost pricing information and the reimbursement made under the maximum allowable cost as defined in s. 627.64741 for a specific drug as being below the acquisition cost available to the challenging pharmacy or pharmacist.

1. The administrative appeal procedure must include a telephone number and e-mail address, or a website, for the purpose of submitting the administrative appeal. The appeal may be submitted by the pharmacy or an agent of the pharmacy directly to the pharmacy benefit manager or through a pharmacy service administration organization. The administrative appeal process must allow a pharmacy or pharmacist the option to submit an electronic spreadsheet or similar electronic document containing a consolidated administrative appeal representing

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multiple adjudicated claims that share the same drug and day supply and have a date of service occurring within the same calendar month. The pharmacy or pharmacist must be given at least 30 business days after a maximum allowable cost update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal.

2. The pharmacy benefit manager must respond to the administrative appeal within 30 business days after receipt of the appeal.

3. If the appeal is upheld, the pharmacy benefit manager must:

a. Update the maximum allowable cost pricing information to at least the acquisition cost available to the pharmacy;

b. Permit the pharmacy or pharmacist to reverse and rebill the claim in question;

c. Provide to the pharmacy or pharmacist the national drug code on which the increase or change is based; and

d. Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable maximum allowable cost pricing information.

4. If the appeal is denied, the pharmacy benefit manager must provide to the pharmacy or pharmacist the national drug code and the name of the national or regional pharmaceutical wholesalers operating in this state which have the drug currently in stock at a price below the maximum allowable cost pricing information.

5. Beginning August 15, 2026 ~~Every 90 days~~, a pharmacy benefit manager shall report to the office the total number of appeals received and denied in the preceding quarter ~~90-day~~

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~~period~~, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted pursuant to this paragraph. The deadlines for each filing are March 1 for the preceding year's fourth quarter; May 15 for each year's first quarter; August 15 for each year's second quarter; and November 15 for each year's third quarter.

Section 8. Subsection (7) of section 626.8827, Florida Statutes, is amended, and subsections (8), (9), and (10) are added to that section, to read:

626.8827 Pharmacy benefit manager prohibited practices.—In addition to other prohibitions in this part, a pharmacy benefit manager may not do any of the following:

(7) Fail to comply with the requirements in s. 624.491 or s. 626.8825, or breach contractual terms required under s. 626.8825.

(8) Prohibit or restrict a pharmacy from declining to dispense a drug if the reimbursement rate for the drug is less than the actual acquisition cost to the pharmacy.

(9) Reimburse a pharmacy less than it reimburses an affiliate pharmacy.

(10) Maintain an ownership interest, investment interest, or common ownership with an affiliated manufacturer, or share any investor or holder of an ownership interest with an affiliated manufacturer.

Section 9. Subsection (1) of section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

(1) As used in this section, the term "health insurer" means an authorized insurer offering health insurance as defined

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in s. 624.603, a managed care plan as defined in s. 409.962 ~~s. 409.962(10)~~, or a health maintenance organization as defined in s. 641.19(12).

Section 10. Except as otherwise provided in this act and except for this section, which shall take effect upon this act becoming a law, 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 health care coverage; amending s. 1.01, F.S.; defining the term "Joint Legislative Committee on Medicaid Oversight"; creating s. 11.405, F.S.; establishing the Joint Legislative Committee on Medicaid Oversight for specified purposes; providing for membership, subcommittees, and meetings of the committee; specifying duties of the committee; authorizing the committee to submit periodic reports to the Legislature; requiring the Auditor General and the Agency for Health Care Administration to enter into and maintain a data sharing agreement for a certain purpose by a specified date; requiring the Auditor General to assist the committee by providing certain staff or consulting services; requiring that state agencies, political subdivisions of the state, and entities contracted with state agencies give the committee access to certain records, papers, and

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documents; authorizing the committee to compel testimony and evidence according to specified provisions; providing for additional powers of the committee; providing that certain joint rules of the Legislature apply to the proceedings of the committee; requiring the agency to notify the committee of certain changes and provide a report containing specified information to the committee; requiring the agency to submit a copy of certain reports to the committee; amending s. 409.962, F.S.; defining terms; amending s. 409.967, F.S.; revising encounter data reporting requirements for prepaid Medicaid plans; requiring the agency's analysis of such encounter data to include identification of specified occurrences; requiring the agency to use such analysis in setting managed care plan capitation rates; requiring that managed care plan contracts require any third-party administrative entity contracted with the plan to adhere to specified requirements; specifying additional types of payments which may not be included in calculating income for purposes of the achieved savings rebate; requiring, rather than authorizing, the agency to calculate the medical loss ratio for all managed care plans under certain circumstances; revising requirements for the calculation of medical loss ratios; requiring the agency to report medical loss ratios quarterly and annually for each managed care plan to the Governor and the Legislature within a specified timeframe; requiring the agency to ensure

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oversight of affiliated entities and related parties paid by managed care plans; requiring the agency to examine specified records and data related to such entities and parties; requiring the agency to consider certain data and findings when developing managed care plan capitation rates; revising the income sharing ratios used to calculate the achieved savings rebate beginning on a specified date; creating s. 409.9675, F.S.; requiring managed care plans to report to the agency and the Office of Insurance Regulation the existence of and specified details relating to certain affiliations by a specified date and annually thereafter; requiring managed care plans to report any change in such information to the agency and the office in writing within a specified timeframe; requiring the agency to calculate, analyze, and publicly report on the agency's website an assessment of affiliated entity payment transactions in the Medicaid program and certain administrative costs by a specified date and annually thereafter; providing requirements for the assessment; amending s. 626.8825, F.S.; defining the terms "affiliated manufacturer" and "covered prescription drug"; revising the definition of the term "pharmacy benefits plan or program"; revising requirements for contracts between a pharmacy benefit manager and a pharmacy benefits plan or program and a participating pharmacy; revising the frequency of and deadlines for certain reports pharmacy benefit managers are required to submit to

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the office beginning on a specified date; amending s. 626.8827, F.S.; revising and specifying additional practices pharmacy benefit managers are prohibited from engaging in; amending s. 627.42392, F.S.; conforming a cross-reference; providing effective dates.

By Senator Brodeur

10-01582-26 20261760__

A bill to be entitled

An act relating to health care coverage; amending s. 1.01, F.S.; defining the term "Joint Legislative Committee on Medicaid Oversight"; creating s. 11.405, F.S.; establishing the Joint Legislative Committee on Medicaid Oversight for specified purposes; providing for membership, subcommittees, and meetings of the committee; specifying duties of the committee; requiring the Auditor General and the Agency for Health Care Administration to enter into a data sharing agreement by a specified date; requiring the Auditor General to assist the committee; requiring that the committee be given access to certain records, papers, and documents; authorizing the committee to compel testimony and evidence according to specified provisions; providing for additional powers of the committee; providing that certain joint rules of the Legislature apply to the proceedings of the committee; requiring the agency to notify the committee of certain changes and provide a report of specified information to the committee; requiring the agency to submit a copy of certain reports to the committee; amending s. 409.962, F.S.; defining the terms "affiliate" and "control"; amending s. 409.967, F.S.; revising encounter data reporting requirements for prepaid Medicaid plans; requiring the agency's analysis of such encounter data to include identification of specified occurrences; requiring the agency to use such analysis in setting managed care

plan capitation rates; requiring that managed care plan contracts require any third-party administrative entity contracted with the plan to adhere to specified requirements; revising the income sharing ratios used to calculate the achieved savings rebate; specifying additional types of payments which may not be included in calculating income for purposes of the achieved savings rebate; requiring, rather than authorizing, the agency to calculate the medical loss ratio for all managed care plans under certain circumstances; revising requirements for the calculation of medical loss ratios; requiring the agency to report medical loss ratios quarterly and annually for each managed care plan to the Governor and the Legislature within a specified timeframe; requiring the agency to ensure oversight of affiliated entities and related parties paid by managed care plans; requiring the agency to examine specified records and data related to such entities and parties; requiring the agency to consider certain data and findings when developing managed care plan capitation rates; creating s. 409.9675, F.S.; requiring managed care plans to report to the agency and the Office of Insurance Regulation the existence of and specified details relating to certain affiliations by a specified date and annually thereafter; requiring managed care plans to report any change in such information to the agency and the office in writing within a specified timeframe; requiring the agency to calculate, analyze, and

publicly report on the agency's website an assessment of affiliated entity payment transactions in the Medicaid program and certain administrative costs by a specified date and annually thereafter; providing requirements for the assessment; amending s. 626.8825, F.S.; defining the term "affiliated manufacturer"; revising requirements for contracts between a pharmacy benefit manager and a pharmacy benefits plan or program and a participating pharmacy; revising the frequency of and deadlines for certain reports pharmacy benefit managers are required to submit to the office; amending s. 626.8827, F.S.; revising and specifying additional practices pharmacy benefit managers are prohibited from engaging in; providing an effective date.

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

Section 1. Subsection (20) is added to section 1.01, Florida Statutes, to read:

1.01 Definitions.—In construing these statutes and each and every word, phrase, or part hereof, where the context will permit:

(20) The term "Joint Legislative Committee on Medicaid Oversight" means a committee or committees designated by joint rule of the Legislature, by the President of the Senate or the Speaker of the House of Representatives, or by agreement between the President of the Senate and the Speaker of the House of Representatives.

Section 2. Section 11.405, Florida Statutes, is created to read:

11.405 Joint Legislative Committee on Medicaid Oversight.—The Joint Legislative Committee on Medicaid Oversight is created to ensure that the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

(1) MEMBERSHIP; SUBCOMMITTEES; MEETINGS.—

(a) The committee shall be composed of five members of the Senate appointed by the President of the Senate and five members of the House of Representatives appointed by the Speaker of the House of Representatives, with each member serving a 2-year term. The chair and vice chair shall be appointed for 1-year terms, with the appointments alternating between the President of the Senate and the Speaker of the House of Representatives. The chair and vice chair may not be members of the same house of the Legislature. If both the chair and vice chair are absent at any meeting, the members present must elect a temporary chair by a majority vote.

(b) Members shall serve without compensation but may be reimbursed for per diem and travel expenses pursuant to s. 112.061.

(c) The chair may establish subcommittees as needed to fulfill the committee's duties.

(d) The committee shall convene at least twice a year, and as often as necessary to conduct its business as required under this section. Meetings may be held through teleconference or other electronic means.

(2) COMMITTEE DUTIES.—

(a) The committee shall evaluate all aspects of the state Medicaid program related to program financing, quality of care and health outcomes, administrative functions, and operational functions to ensure that the program is providing transparency in the provision of health care plans and providers, ensuring Medicaid recipients have access to quality health care services, and providing stability to the state's budget through a health care delivery system designed to contain costs.

(b) The committee shall identify and recommend policies that limit Medicaid spending growth while improving health care outcomes for Medicaid recipients. In developing its recommendations, the committee shall do all of the following:

1. Evaluate legislation for its long-term impact on the state Medicaid program.

2. Review data submitted to the agency by the Medicaid managed care plans pursuant to statutory and contract requirements, including, but not limited to, timeliness of provider credentialing, timely payment of claims, rate of claim denials, prior authorizations for services, and consumer complaints.

3. Review the Medicaid managed care plans' encounter data, financial data, and audits and the data used to calculate the plans' achieved savings rebates and medical loss ratios.

4. Review data related to health outcomes of Medicaid recipients, including, but not limited to, Health Effectiveness Data and Information Set measures developed by the National Committee for Quality Assurance for each Medicaid managed care plan, each Medicaid managed care plan's performance improvement projects, and outcome data related to all quality goals included

in the Medicaid managed care organization contracts to improve quality for recipients.

5. Identify any areas for improvement in statute and rule relating to the state Medicaid program.

6. Develop a plan of action for the future of the state Medicaid program.

(c) The committee may submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

(3) COOPERATION.—

(a) The Auditor General and the Agency for Health Care Administration shall enter into and maintain a data sharing agreement by July 1, 2026, to ensure the committee has full access to all data needed to fulfill its responsibilities.

(b) The Auditor General shall assist the committee in its work by providing credentialed professional staff or consulting services, including, but not limited to, an actuary not associated with the state Medicaid program or any Medicaid managed care organization who currently has a contract with the state.

(c) The committee, in the course of its official duties, must be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of the state, or any entity engaged in business or under contract with a state agency, and may compel the attendance and testimony of any state official or employee before the committee or secure any evidence as provided in s. 11.143. The committee shall also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of

the Senate and the House of Representatives applicable to joint legislative committees apply to the proceedings of the committee under this section.

(4) AGENCY REPORTS.—

(a) Before implementing any change to the Medicaid managed care capitation rates, the Agency for Health Care Administration shall notify the committee of the change and appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates. The report must include the agency's historical and projected Medicaid program expenditure and utilization trend rates by Medicaid program and service category for the rate year, an explanation of how the trend rates were calculated, and the policy decisions that were included in setting the capitation rates.

(b) If the Agency for Health Care Administration or any division within the agency is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the agency must also submit a copy of the report to the committee.

Section 3. Present subsections (2) through (5) and (6) through (18) of section 409.962, Florida Statutes, are redesignated as subsections (3) through (6) and (8) through (20), respectively, and new subsections (2) and (7) are added to that section, to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(2) "Affiliate," including the terms "affiliated with" and "affiliation," means a person, as construed in s. 1.01(3), who:

(a) Directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person, including parent and subsidiary entities; or

(b) Is deemed a "related party" according to the standards adopted by the Financial Accounting Standards Board.

(7) "Control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership or voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. This definition applies regardless of whether such power is affirmative or negative or whether such power is actually used. Control is presumed to exist, but is not limited to, when any affiliate or person, as construed in s. 1.01(3):

(a) Directly or indirectly owns, controls, holds the power to vote, or holds proxies representing 10 percent or more of any class of the voting securities of any other person.

(b) Shares common ownership with any person, has an investor or is a holder of an ownership interest in any person, exercises control in any manner over the election of a majority of the directors or of individuals exercising similar functions of any person, has the power to exercise controlling influence over the management of any person, or serves as a working majority of the board of directors, managers, or the officers of a person, who is:

1. A provider or a member of a provider group or group practice as defined in s. 456.053 under the managed care plan; or

2. A person responsible for providing any pharmacy services, pharmaceuticals, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services under the managed care plan.

Section 4. Subsections (1) and (2), paragraphs (f), (g), and (h) of subsection (3), and subsection (4) of section 409.967, Florida Statutes, are amended, and subsection (5) is added to that section, to read:

409.967 Managed care plan accountability.—

(1) CONTRACT PROCUREMENT PROCESS.—Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

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

(a) *Physician compensation.*—Managed care plans are expected

to coordinate care, manage chronic disease, and prevent the need for more costly services. Effective care management should enable plans to redirect available resources and increase compensation for physicians. Plans achieve this performance standard when physician payment rates equal or exceed Medicare rates for similar services. The agency may impose fines or other sanctions on a plan that fails to meet this performance standard after 2 years of continuous operation.

(b) *Emergency services.*—Managed care plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider. The plans must comply with s. 641.3155. Reimbursement for services under this paragraph is the lesser of:

1. The provider's charges;

2. The usual and customary provider charges for similar services in the community where the services were provided;

3. The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

4. The Medicaid rate, which, for the purposes of this paragraph, means the amount the provider would collect from the agency on a fee-for-service basis, less any amounts for the indirect costs of medical education and the direct costs of graduate medical education that are otherwise included in the agency's fee-for-service payment, as required under 42 U.S.C. s. 1396u-2(b)(2)(D). For the purpose of establishing the amounts specified in this subparagraph, the agency shall publish on its website annually, or more frequently as needed, the applicable fee-for-service fee schedules and their effective dates, less any amounts for indirect costs of medical education and direct

costs of graduate medical education that are otherwise included in the agency's fee-for-service payments.

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

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

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

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

plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and follow-up ~~followup~~ on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(d) *Quality care.*—Managed care plans shall provide, or contract for the provision of, care coordination to facilitate the appropriate delivery of behavioral health care services in the least restrictive setting with treatment and recovery capabilities that address the needs of the patient. Services shall be provided in a manner that integrates behavioral health services and primary care. Plans shall be required to achieve specific behavioral health outcome standards, established by the agency in consultation with the department.

(e) *Encounter data.*—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data, including data on encounters for which payment was denied and encounters for which a health care provider was reimbursed by the plan on a capitated basis, electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data

submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of overspending on administrative costs, payments by plans in excess of market rates, systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters, and potential managed care plan fraud, waste, and abuse. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs. The analysis shall be used in managed care plan capitation rate-setting processes provided under this part.

3. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

4. The agency shall annually produce a report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees." The report must include, but need not be limited to, an analysis of the potentially preventable hospital emergency department visits, hospital admissions, and hospital readmissions that occurred during the previous state fiscal year which may have been prevented with better access to primary care, improved medication management, or better coordination of care, reported by age, eligibility group, managed care plan, and region, including conditions contributing

to each potentially preventable event or category of potentially preventable events. The agency may include any other data or analysis parameters to augment the report which it deems pertinent to the analysis. The report must demonstrate trends using applicable historical data. The agency shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The agency may contract with a third-party vendor to produce the report required under this subparagraph.

(f) *Continuous improvement.*—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

2. Each managed care plan must collect and report the Healthcare Effectiveness Data and Information Set (HEDIS) measures, the federal Core Set of Children’s Health Care Quality measures, and the federal Core Set of Adult Health Care Quality Measures, as specified by the agency. Each plan must collect and report the Adult Core Set behavioral health measures beginning with data reports for the 2025 calendar year. Each plan must stratify reported measures by age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of

Supplemental Security Income beginning with data reports for the 2026 calendar year. A plan's performance on these measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under ss. 409.977 and 409.984.

(g) *Program integrity.*—Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

1. A provider credentialing system and ongoing provider monitoring, including maintenance of written provider credentialing policies and procedures which comply with federal and agency guidelines;

2. An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

3. Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

4. Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

5. Designation of a program integrity compliance officer.

(h) *Grievance resolution.*—Consistent with federal law, each managed care plan shall establish and the agency shall approve an internal process for reviewing and responding to grievances from enrollees. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees.

(i) *Penalties.*—

1. Withdrawal and enrollment reduction.—Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the agency for the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per-enrollee penalty of up to 3 months' payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other departing plans must pay a penalty of 25 percent of that portion of the minimum surplus maintained pursuant to s. 641.225(1) which is attributable to the provision of coverage to Medicaid enrollees. Plans shall provide at least 180 days' notice to the agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the agency shall terminate all contracts with that plan in other regions pursuant to the termination procedures in subparagraph 3.

2. Encounter data.—If a plan fails to comply with the encounter data reporting requirements of this section for 30

days, the agency must assess a fine of $5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

3. Termination.—If the agency terminates more than one regional contract with the same managed care plan due to noncompliance with the requirements of this section, the agency shall terminate all the regional contracts held by that plan. When terminating multiple contracts, the agency must develop a plan to provide for the transition of enrollees to other plans, and phase in the terminations over a time period sufficient to ensure a smooth transition.

(j) *Prompt payment.*—Managed care plans shall comply with ss. 641.315, 641.3155, and 641.513.

(k) *Electronic claims.*—Managed care plans, and their fiscal agents or intermediaries, shall accept electronic claims in compliance with federal standards.

(l) *Fair payment.*—Provider service networks must ensure that no entity licensed under chapter 395 with a controlling interest in the network charges a Medicaid managed care plan more than the amount paid to that provider by the provider service network for the same service.

(m) *Itemized payment.*—Any claims payment to a provider by a managed care plan, or by a fiscal agent or intermediary of the plan, must be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee’s name, the date of service, the procedure code, the amount of reimbursement, and the

identification of the plan on whose behalf the payment is made.

(n) *Provider dispute resolution.*—Disputes between a plan and a provider may be resolved as described in s. 408.7057.

(o) *Transparency.*—Managed care plans shall comply with ss. 627.6385(3) and 641.54(7).

(p) *Third-party administrators.*—The agency's contract with a managed care plan must require that any third-party administrative entity contracted by the plan adheres to all pertinent requirements of the Medicaid program placed on the plan under the plan's contract with the agency.

(3) ACHIEVED SAVINGS REBATE.—

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 3 ~~5~~ percent of revenue shall be retained by the plan.

2. Thirty ~~Fifty~~ percent of income above 3 ~~5~~ percent and up to 10 percent shall be retained by the plan, and the other 70 ~~50~~ percent shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be

transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

(g) A plan that exceeds agency-defined quality measures in the reporting period may retain an additional 1 percent of revenue. For the purpose of this paragraph, the quality measures must include plan performance for preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

(h) The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:

1. Payment of achieved savings rebates.

2. Any financial incentive payments made to the plan outside of the capitation rate.

3. Any financial disincentive payments levied by the state or Federal Government.

4. Expenses associated with any lobbying or political activities.

5. The cash value or equivalent cash value of bonuses of any type paid or awarded to the plan’s executive staff, other than base salary.

6. Reserves and reserve accounts.

7. Administrative costs, including, but not limited to, reinsurance expenses, interest payments, depreciation expenses, bad debt expenses, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the agency.

8. Payments to affiliated entities as defined in s. 409.962 in excess of market rates.

The agency shall consider these and other factors in developing contracts that establish shared savings arrangements.

(4) MEDICAL LOSS RATIOS ~~RATIO~~.—

(a) If required by federal regulations or as a condition of a waiver, the agency must ~~may~~ calculate ~~a~~ medical loss ratios ~~ratio~~ for all managed care plans contracted with the agency under this part. The calculations must ~~calculation shall~~ use uniform financial data collected from all plans ~~and shall be computed for each plan on a statewide basis~~. If a plan participates in the managed medical assistance program, the long-term care managed care program, or the pilot program for individuals with developmental disabilities, the agency must calculate medical loss ratios for the plan's participation in each program separately and, if the plan participates in more than one of these programs, for the plan's overall participation in statewide Medicaid managed care. ~~The method for calculating the medical loss ratio shall meet the following criteria:~~

~~(a) Except as provided in paragraphs (b) and (c),~~ Medical loss ratios must be calculated and expenditures must ~~shall~~ be classified in a manner consistent with 42 C.F.R. part 438 ~~45 C.F.R. part 158~~.

(b) The agency shall report medical loss ratios quarterly and annually for each managed care plan contracted with the agency under this part to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than 6 months after the end of each such period ~~Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified~~

~~as medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.~~

~~(c) Before final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period. Funds contributed for this purpose shall be deposited into the Grants and Donations Trust Fund~~.

(5) AFFILIATED ENTITIES AND RELATED PARTIES.—

(a) The agency shall ensure oversight of affiliated entities and related parties paid by managed care plans under this part, including, but not limited to, examining financial records and self-referral data of any managed care plan providing services within the statewide managed care program which uses affiliated entities and related parties.

(b) The agency shall consider data examined under paragraph (a) and the findings of the annual assessment required under s. 409.9675(4) when developing managed care plan capitation rates under this part.

Section 5. Section 409.9675, Florida Statutes, is created to read:

409.9675 Affiliated entities and controlling interests; reports required.—

(1) Each managed care plan contracted by the agency under this part shall report all of the following by March 31, 2027, for the prior calendar year, and annually thereafter, to the

agency and the Office of Insurance Regulation in the manner prescribed by the agency:

(a) Any person controlled by or affiliated with the managed care plan, including, but not limited to, any provider, provider group, group practice defined in s. 456.053(3), or person responsible for providing any pharmacy services, pharmaceuticals, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services for, to, or on behalf of the managed care plan.

(b) Any affiliation of any kind or nature with any person which has, either directly or indirectly through one or more intermediaries, an investment or ownership interest representing 10 percent or more, shares common ownership with, or has an investor or a holder of an ownership interest representing 10 percent or more with any person providing pharmacy services, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services for, to, or on behalf of the managed care plan.

(2) For any affiliation reported by a managed care plan under subsection (1), the report must include all of the following:

(a) The percentage of ownership or control of any person or affiliate with whom the managed care plan has had business transactions totaling in the aggregate more than $25,000 during the prior 12-month period in the annual achieved savings rebate financial reporting required under s. 409.967(3) and identification of the specific contract or contracts involved in

such business transactions.

(b) Any significant business transactions between the managed care plan and any affiliated person during the 12-month period in the annual achieved savings rebate financial reporting required under s. 409.967(3).

(3) Each managed care plan shall report any change in information required by subsection (1) to the agency and the Office of Insurance Regulation in writing within 60 days after the change occurs.

(4) By December 31, 2026, and annually thereafter, the agency shall calculate, analyze, and publicly report on the agency's website an assessment of affiliated entity payment transactions in the Medicaid program for medical benefit and administrative costs as reported for purposes of the achieved savings rebate. The baseline assessment, at a minimum, must include achieved savings rebate transactions for the years 2021, 2022, and 2023; the amount and associated percentage of affiliated entity payments within the medical loss ratio; and the payment deviation percentages and associated amounts at the Healthcare Common Procedure Coding System level for affiliated entities as compared to nonaffiliated entities. The assessment must also compare payment amounts for value-based or alternative payment arrangements.

Section 6. Present paragraphs (b) through (x) of subsection (1) of section 626.8825, Florida Statutes, are redesignated as paragraphs (c) through (y), respectively, a new paragraph (b) is added to that subsection, and paragraph (g) of subsection (2) and paragraphs (c) and (h) of subsection (3) of that section are amended, to read:

626.8825 Pharmacy benefit manager transparency and accountability.—

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

(b) "Affiliated manufacturer" means a prescription drug manufacturer permitted under part I of chapter 499, or an entity that contracts with a prescription drug manufacturer or nonresident prescription drug manufacturer permitted under part I of chapter 499 or an affiliate thereof for the promotion and marketing of prescription drugs, which prescription drug manufacturer or contracting entity directly or indirectly through one or more intermediaries:

1. Has an investment or ownership interest in a pharmacy benefit manager holding a certificate of authority issued under this part;

2. Shares common ownership with a pharmacy benefit manager holding a certificate of authority issued under this part; or

3. Has an investor or a holder of an ownership interest which is a pharmacy benefit manager holding a certificate of authority issued under this part.

(2) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A PHARMACY BENEFITS PLAN OR PROGRAM.—In addition to any other requirements in the Florida Insurance Code, all contractual arrangements executed, amended, adjusted, or renewed on or after July 1, 2023, which are applicable to pharmacy benefits covered on or after January 1, 2024, between a pharmacy benefit manager and a pharmacy benefits plan or program must include, in substantial form, terms that ensure compliance with all of the following requirements and that, except to the extent not allowed by law, shall supersede any contractual terms to the

contrary:

(g) Prohibit a pharmacy benefit manager from instituting a network that requires a pharmacy to meet accreditation standards inconsistent with or more stringent than applicable federal and state requirements for licensure and operation as a pharmacy in this state. However, a pharmacy benefit manager may specify additional specialty networks that require enhanced standards related to the safety and competency necessary to meet the United States Food and Drug Administration's limited distribution requirements for dispensing any drug that, on a drug-by-drug basis, requires extraordinary special handling, ~~provider coordination, or clinical care or monitoring~~ when such extraordinary requirements cannot be met by a retail pharmacy. For purposes of this paragraph, drugs requiring extraordinary special handling are limited to drugs that are subject to a risk evaluation and mitigation strategy approved by the United States Food and Drug Administration and that:

1. Require special certification of a health care provider to prescribe, receive, dispense, or administer; or

2. Require special handling due to the molecular complexity or cytotoxic properties of the biologic or biosimilar product or drug.

For participation in a specialty network, a pharmacy benefit manager may not deny ~~require~~ a pharmacy ~~to meet requirements for~~ participation if the pharmacy can ~~beyond those necessary to~~ demonstrate the pharmacy's ability to dispense the drug in accordance with the United States Food and Drug Administration's approved manufacturer labeling.

(3) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A PARTICIPATING PHARMACY.—In addition to other requirements in the Florida Insurance Code, a participation contract executed, amended, adjusted, or renewed on or after July 1, 2023, that applies to pharmacist services on or after January 1, 2024, between a pharmacy benefit manager and one or more pharmacies or pharmacists, must include, in substantial form, terms that ensure compliance with all of the following requirements, and that, except to the extent not allowed by law, shall supersede any contractual terms in the participation contract to the contrary:

(c) A prohibition of financial clawbacks, reconciliation offsets, or offsets to adjudicated claims. A pharmacy benefit manager may not charge, withhold, offset, or recoup any direct or indirect remuneration fees, dispensing fees, brand name or generic effective rate adjustments through reconciliation, or any other monetary charge, withholding, or recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when an amount ~~a fee~~ may be recouped from a pharmacy if such action would result in a reduction in the amount paid to the pharmacy or pharmacist. This prohibition does not apply to:

1. Any incentive payments provided by the pharmacy benefit manager to a network pharmacy for meeting or exceeding predefined quality measures, such as Healthcare Effectiveness Data and Information Set measures; recoupment due to an erroneous claim, fraud, waste, or abuse; a claim adjudicated in error; a maximum allowable cost appeal pricing adjustment; or an adjustment made as part of a pharmacy audit pursuant to s.

624.491.

2. Any recoupment that is returned to the state for programs in chapter 409 or the state group insurance program in s. 110.123.

(h) The pharmacy benefit manager shall provide a reasonable administrative appeal procedure to allow a pharmacy or pharmacist to challenge the maximum allowable cost pricing information and the reimbursement made under the maximum allowable cost as defined in s. 627.64741 for a specific drug as being below the acquisition cost available to the challenging pharmacy or pharmacist.

1. The administrative appeal procedure must include a telephone number and e-mail address, or a website, for the purpose of submitting the administrative appeal. The appeal may be submitted by the pharmacy or an agent of the pharmacy directly to the pharmacy benefit manager or through a pharmacy service administration organization. The administrative appeal process must allow a pharmacy or pharmacist the option to submit an electronic spreadsheet or similar electronic document containing a consolidated administrative appeal representing multiple adjudicated claims that share the same drug and day supply and have a date of service occurring within the same calendar month. The pharmacy or pharmacist must be given at least 30 business days after a maximum allowable cost update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal.

2. The pharmacy benefit manager must respond to the administrative appeal within 30 business days after receipt of the appeal.

3. If the appeal is upheld, the pharmacy benefit manager must:

a. Update the maximum allowable cost pricing information to at least the acquisition cost available to the pharmacy;

b. Permit the pharmacy or pharmacist to reverse and rebill the claim in question;

c. Provide to the pharmacy or pharmacist the national drug code on which the increase or change is based; and

d. Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable maximum allowable cost pricing information.

4. If the appeal is denied, the pharmacy benefit manager must provide to the pharmacy or pharmacist the national drug code and the name of the national or regional pharmaceutical wholesalers operating in this state which have the drug currently in stock at a price below the maximum allowable cost pricing information.

5. Beginning August 15, 2026 ~~Every 90 days~~, a pharmacy benefit manager shall report to the office the total number of appeals received and denied in the preceding quarter ~~90-day period~~, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted pursuant to this paragraph. The deadlines for each filing are March 1 for the preceding year's 4th quarter; May 15 for each year's first quarter; August 15 for each year's second quarter; and November 15 for each year's third quarter.

Section 7. Subsection (7) of section 626.8827, Florida Statutes, is amended, and subsections (8) through (11) are added to that section, to read:

626.8827 Pharmacy benefit manager prohibited practices.—In addition to other prohibitions in this part, a pharmacy benefit manager may not do any of the following:

(7) Fail to comply with the requirements in s. 624.491 or s. 626.8825, or breach contractual terms required under s. 626.8825.

(8) Prohibit or restrict a pharmacy from declining to dispense a drug if the reimbursement rate for the drug is less than the actual acquisition cost to the pharmacy.

(9) Fail to reimburse a pharmacy or pharmacist a minimum dispensing fee. The minimum dispensing fee must be an amount no less than $10.24. The minimum dispensing fee set forth in this subsection automatically adjusts every January 1 in an amount equal to the average percentage change in the Consumer Price Index for medical care for all urban consumers over the immediately preceding 12-month period. The office may revise the minimum dispensing fee upon reasonably determining that the current minimum dispensing fee provides excessive or inadequate payments to pharmacies when compared with such payments made in other states, provided that any adjustment by the office does not result in a dispensing fee less than the current Florida Medicaid dispensing fee for covered outpatient prescription drugs.

(10) Reimburse a pharmacy less than it reimburses an affiliate pharmacy.

(11) Maintain an ownership interest, investment interest, or common ownership with an affiliated manufacturer, or share any investor or holder of an ownership interest with an affiliated manufacturer.

Section 8. This act shall take effect July 1, 2026.