Bill Number

Tab 1	**CS/SB 12** by **JU, Gruters;** Similar to CS/H 06511 Relief of L.P., a Minor, by the Department of Children and Families

Tab 2	**CS/SB 526** by **HP, Harrell (CO-INTRODUCERS) Sharief;** Similar to H 00919 Nursing Education Programs

698194	D	S	AHS, Harrell	Delete everything after	04/13 04:22 PM

Tab 3	**CS/SB 614** by **CF, Polsky;** Similar to CS/CS/H 00531 Public Education of Background Screening Requirements

Tab 4	**SB 890** by **Yarborough (CO-INTRODUCERS) Berman;** Similar to CS/CS/H 01421 Improving Screening for and Treatment of Blood Clots

185632	D	S	AHS, Yarborough	Delete everything after	04/14 09:47 AM

Tab 5	**CS/SB 954** by **CA, Gruters (CO-INTRODUCERS) Rouson;** Similar to CS/CS/H 01163 Certified Recovery Residences

Tab 6	**CS/SB 1050** by **CF, Bradley;** Similar to CS/H 01103 Services for Individuals with Developmental Disabilities

Tab 7	**SB 1060** by **Brodeur;** Identical to H 00935 Medicaid Oversight

509320	A	S	AHS, Brodeur	Delete L.26 - 36:	04/14 09:49 AM

Tab 8	**CS/SB 1144** by **GO, Burgess;** Similar to H 01327 Hope Florida

Tab 9	**CS/SB 1146** by **GO, Burgess;** Similar to CS/H 01329 Public Records/Hope Florida Program

Tab 10	**SB 1182** by **Harrell;** Identical to CS/H 01465 Medicaid Coverage of Continuous Glucose Monitors

Tab 11	**CS/SB 1224** by **HP, Harrell;** Identical to CS/H 00519 Administration of Controlled Substances

Tab 12	**CS/SB 1240** by **CF, Calatayud;** Similar to CS/H 01091 Substance Abuse and Mental Health Care

532552	A	S	AHS, Calatayud	btw L.118 - 119:	04/13 04:23 PM

Tab 13	**SB 1578** by **Davis;** Similar to H 00187 Coverage for Mammograms and Supplemental Breast Cancer Screenings

Tab 14	**CS/SB 1602** by **HP, Harrell;** Identical to CS/H 01119 Health Care Patient Protection

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Tuesday, April 15, 2025
TIME: 8:30 a.m.—12:00 noon
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**CS/SB 12** Judiciary / Gruters (Similar CS/H 6511)	Relief of L.P., a Minor, by the Department of Children and Families; Providing for the relief of L.P., a minor, by the Department of Children and Families; providing an appropriation to a special needs trust, to compensate L.P. for injuries and damages sustained due to the negligence of employees and caseworkers of the department; providing a limitation on compensation and the payment of fees and costs, etc. SM JU 04/01/2025 Fav/CS AHS 04/15/2025 AP	
2	**CS/SB 526** Health Policy / Harrell (Similar H 919)	Nursing Education Programs; Revising application requirements for nursing education program approval; providing for the revocation of a program's approval, and discipline of its program director, under certain circumstances; authorizing agents of the Department of Health to conduct onsite evaluations and inspections of approved and accredited nursing education programs; deeming failure or refusal of a program to allow such evaluation or inspection as a violation of a legal obligation, etc. HP 03/04/2025 Fav/CS AHS 04/15/2025 FP	
3	**CS/SB 614** Children, Families, and Elder Affairs / Polsky (Similar CS/CS/H 531)	Public Education of Background Screening Requirements; Requiring the Agency for Health Care Administration and the Department of Law Enforcement, in consultation with certain agencies, to develop and maintain a care provider background screening education and awareness webpage; providing requirements for resources provided on the webpage; requiring that specified agencies provide a link to the webpage on their respective websites and promote the inclusion of the link in certain media, etc. CF 04/01/2025 Fav/CS AHS 04/15/2025 FP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 890** Yarborough (Similar CS/CS/H 1421)	Improving Screening for and Treatment of Blood Clots; Requiring the Department of Health to establish, or contract to establish, a statewide registry for a specified purpose; providing that certain personal identifying information is confidential and exempt from public records requirements, with exceptions; requiring certain licensed facilities to arrange for the rendering of appropriate medical attention for persons at risk for certain conditions; revising requirements for certain annual inservice training for certified nursing assistants employed by nursing home facilities, etc. HP 03/11/2025 Favorable AHS 04/15/2025 FP	
5	**CS/SB 954** Community Affairs / Gruters (Similar CS/CS/H 1163)	Certified Recovery Residences; Providing that certain recovery residences are deemed a nontransient residential use of land for a specified purpose; prohibiting a local law, ordinance, or regulation from prohibiting or regulating a recovery residence in a multifamily structure; requiring a county or a municipality to allow certain certified recovery residences in specified zoned districts without the need to obtain changes in certain zoning or land use; providing that the personnel-to-resident ratio for a certified recovery residence must be met only when the residents are at the residence, etc. CA 03/31/2025 Fav/CS AHS 04/15/2025 RC	
6	**CS/SB 1050** Children, Families, and Elder Affairs / Bradley (Similar CS/H 1103)	Services for Individuals with Developmental Disabilities; Requiring the Agency for Persons with Disabilities to post its quarterly reconciliation reports on its website within a specified timeframe; providing a requirement for the online application system to allow an applicant to apply for crisis enrollment; requiring the agency to implement a specified Medicaid waiver program to address the needs of certain clients, etc. CF 04/01/2025 Fav/CS AHS 04/15/2025 AP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1060** Brodeur (Identical H 935)	Medicaid Oversight; Establishing the Joint Legislative Committee on Medicaid Oversight within the Office of the Auditor General for specified purposes; requiring the Auditor General and the Agency for Health Care Administration to enter into a data sharing agreement by a specified date; providing that the committee must be given access to certain records, papers, and documents, etc. HP 03/18/2025 Favorable AHS 04/15/2025 AP	
8	**CS/SB 1144** Governmental Oversight and Accountability / Burgess (Similar H 1327, Compare CS/H 1329, Linked CS/S 1146)	Hope Florida; Creating the "Hope Florida Act"; creating the Hope Florida Office within the Executive Office of the Governor; providing eligibility requirements for Hope Florida participants; requiring the office to designate a state agency to perform certain functions; requiring that Hope Navigators be embedded in communities for specified purposes, etc. GO 04/01/2025 Fav/CS AHS 04/15/2025 AP	
9	**CS/SB 1146** Governmental Oversight and Accountability / Burgess (Similar CS/H 1329, Compare H 1327, Linked CS/S 1144)	Public Records/Hope Florida Program ; Providing an exemption from public records requirements for the personal identifying information of a participant in the Hope Florida program contained in records held by the Hope Florida Office or any other agency designated to participate in the administering the program; providing retroactive application; providing for future legislative review and repeal; providing a statement of public necessity, etc. GO 04/01/2025 Fav/CS AHS 04/15/2025 AP	
10	**SB 1182** Harrell (Identical CS/H 1465)	Medicaid Coverage of Continuous Glucose Monitors; Requiring the Agency for Health Care Administration to, within a specified timeframe, seek federal approval as needed to provide coverage of continuous glucose monitors and related supplies as a durable medical equipment benefit under the Medicaid program; requiring the agency to implement these changes upon receiving any necessary federal approval, etc. HP 04/01/2025 Favorable AHS 04/15/2025 FP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
11	**CS/SB 1224** Health Policy / Harrell (Identical CS/H 519)	Administration of Controlled Substances; Authorizing a practitioner to cause a controlled substance to be administered by a certified paramedic in the course of providing emergency services, etc. HP 03/25/2025 Fav/CS AHS 04/15/2025 RC	
12	**CS/SB 1240** Children, Families, and Elder Affairs / Calatayud (Similar CS/H 1091)	Substance Abuse and Mental Health Care; Expanding mental health crisis services to include the 988 suicide and crisis lifeline call center; authorizing the guardian advocate to be discharged when a patient is discharged from involuntary outpatient services; providing that orders entered by administrative law judges for continued involuntary placement for patients at certain mental health facilities are final and subject to judicial review, etc. CF 03/19/2025 Fav/CS AHS 04/15/2025 RC	
13	**SB 1578** Davis (Similar H 187)	Coverage for Mammograms and Supplemental Breast Cancer Screenings; Requiring the Agency for Health Care Administration to provide Medicaid coverage for annual mammograms and supplemental breast cancer screenings for certain women meeting specified criteria, subject to the availability of funds and any limitations or directions the Legislature provides in the General Appropriations Act; revising coverage for mammograms under certain individual accident and health insurance policies, certain group, blanket, and franchise accident and health insurance policies, and certain health maintenance contracts, respectively, etc. BI 03/25/2025 Favorable AHS 04/15/2025 FP	
14	**CS/SB 1602** Health Policy / Harrell (Identical CS/H 1119)	Health Care Patient Protection; Requiring hospital emergency departments to develop and implement policies and procedures, conduct training, record weights in a certain manner, designate a pediatric emergency care coordinator, and conduct specified assessments; requiring the Agency for Health Care Administration to adopt certain rules for comprehensive emergency management plans; requiring the agency to collect and publish the results of specified assessments submitted by hospitals by specified dates, etc. HP 04/01/2025 Fav/CS AHS 04/15/2025 FP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	Other Related Meeting Documents		

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
409 The Capitol

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

DATE	COMM	ACTION
03/27/2025	SM	Favorable
04/01/25	JU	Fav/CS
04/14/25	AHS	Pre-meeting
	AP	

March 27, 2025

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

Re: **CS/SB 12** – Judiciary Committee and Senator Gruters
HB 6511 – Representative Busatta
Relief of L.P. by the Department of Children and Families

SPECIAL MASTER'S FINAL REPORT

THIS IS A CLAIM FOR $28 MILLION BASED ON A JURY VERDICT AGAINST THE DEPARTMENT OF CHILDREN AND FAMILIES ("DEPARTMENT") FOR INJURIES AND DAMAGES ARISING FROM THE DEPARTMENT'S NEGLIGENCE THAT RESULTED IN L.P.'S MOTHER STABBING HER 14 TIMES ON JUNE 26, 2015.

Background

L.P. is the biological daughter of Ashely Parker.[1] The two lived together in Sarasota in a home owned by Ms. Parker's mother, Valerie Carey (V.D.C), up until June 26, 2015. Records indicate that L.P. does not have a relationship with her biological father.[2] V.D.C. and Sidney Carey (S.C.), V.D.C.'s husband, adopted L.X.C. with a name change from L.X.P. to L.X.C. on March 30, 2017.[3]

L.P. is 15 years old and lives with her adoptive parents, her grandparents, where she enjoys living. She is in 9th grade and

[1] Claim Bill Hearing 2:28:30-2:28:57 (Jan. 31, 2025) (hereinafter referred to as "Hearing").
[2] Plaintiff's Trial Exhibit 110, Shahnasarian, M. *Vocational Rehabilitation Evaluation of L.X.C.*, 12 (Aug. 30, 2021) (hereinafter referred to as "Evaluation").
[3] Hearing at 4:52:47-4:52:50; Evaluation at 9.

attends high school.[4] After school, she practices gymnastics and attends therapy every Monday.[5] On the weekends, she hangs out with her friends. She wants to attend the University of South Florida (USF) and become a marine biologist. [6]

History of Interactions with Police Department

V.D.C. denied any knowledge of Ms. Parker having a juvenile record. However, she testified that Ms. Parker got into a fight with S.C. and V.D.C. called the police. She does not recall how old Ms. Parker was when the incident occurred. She also testified about a fight that happened at school.[7]

March 9, 2015: Ms. Parker contacted Sarasota Police Department (SPD) alleging that her ex-boyfriend, Mr. Mattson, wanted her dead and was trying to kill her. She reported not knowing why or how he was going to hurt her but suggested that Parker (sic) cuts her brakes on her truck every night. SPD saw no evidence of any signs that Ms. Parker's brakes had been cut and advised her to call 911 if Mattson came over. No action was taken.[8]

March 11, 2009: Ms. Parker was charged with making a false report to the law enforcement authorities which she pled guilty to on March 3, 2010.[9]

March 11, 2009: Ms. Parker was charged with neglect of a child-with great harm, a second-degree felony. On February 16, 2010, Ms. Parker entered into a plea agreement and was given five (5) years of probation.[10]

September 14, 2009: Ms. Parker was charged with four (4) counts of making false reports of commission of crime which she pled guilty to on March 3, 2010.[11]

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[4] Hearing at 1:58:00-2:06:24.
[5] *Id.* at 5:34:00-5:34:35.
[6] *Id.* at 1:58:00-2:06:24.
[7] *Id.* at 4:56:30-4:59:48.
[8] Department's Composite Exhibit, *Callouts to AP's home (unredacted)*, 5 (June 26, 2015) (hereinafter referred to as "Callouts").
[9] *State of Florida v. Ashley Yvonne Parker*, case no. 2009MM012141 (Mar. 3, 2010).
[10] Lopez T-IV 1065: 19-20; *State of Florida v. Ashley Yvonne Parker*, 2009CF003576 (Mar. 11, 2009). The Department reports that an investigation was conducted in connection with this case. The child victim was a foster child who was placed with Ms. Parker before L.P. was born. The case closed with "Some Indicators of Inadequate Supervision and Some Indicators of Threatened Harm."
[11] *State of Florida v. Ashley Yvonne Parker*, case no. 2009MM013313 (Sept. 14, 2009).

March 26, 2015: Ms. Parker contacted SPD alleging that someone was threatening to kidnap her and L.P. Ms. Parker reported hearing a "suspicious noise" near her home.[12]

April 17, 2015: Ms. Parker sent a suicide note to SPD. Officer Luciano spoke with Ms. Parker and V.D.C. at Ms. Parker's home and both denied that Ms. Parker was suicidal. Ms. Parker denied writing any such note. Ms. Parker was highly agitated and expressed that she was "scared of police." V.D.C. declined to give her name or any other information.[13]

May 13, 2015: SPD responded to Ms. Parker's home at 11:21 p.m. where she reported that she could not come outside due to a man holding a gun to her head which SPD noted that "clearly there was no one around her." Ms. Parker exited the home and began making statements, for instance, that people were going to kill her and that her cousin had sent her a video of her daughter, L.P., being molested. SPD took Ms. Parker into custody under a Baker Act and transported her to Sarasota Memorial Hospital for evaluation. SPD spoke to L.P. who appeared fine and not in any distress or danger. Based on this limited observation, the SDP determined that, "It did not appear the allegations of L.P. being molested to be true due to the deranged state Parker was in when she alleged such."[14] There was no corresponding abuse report made on this date.

Note: Ms. Parker was evaluated at Sarasota Memorial Hospital which resulted in clinical impressions/a problem list of psychosis and medical clearance. Ms. Parker's disposition was reported as stable, and her status was reported as transfer. She was transported to Coastal for psychiatric evaluation. The evaluation determined that there was no psychosis present, and she was discharged by 9:00 a.m. on May 14, 2015, less than ten hours after arrival.[15]

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[12] Claimant's Exhibit 13, *15-015709 Incident Report*, 2 (Mar. 26, 2015).
[13] Callouts at 9.
[14] Claimant's Exhibit 16, *15-024631 Incident Report*, 3 (May 13, 2015).
[15] Department's Exhibit 9, *Coastal Behavioral Healthcare* (May 14, 2015). Ms. Parker was Baker Acted once before this Baker Act in May 2015 because of her fight with S.C. She was in a facility for months. Ms. Parker was a teenager living with V.D.C. in Bradenton. V.D.C. testified that Ms. Parker was Baker Acted a total of two times. Hearing at 4:56:55-5:59:48.

May 15, 2015: SPD attempted to contact Ms. Parker at her home in Sarasota, in reference to a suspicious incident but no one was home.[16]

May 29, 2015: Ms. Parker walked into SPD to report multiple suspicious incidents over a span of several months. Officers asked her if the threats/harassment calls had been previously reported and Ms. Parker confirmed that she had. SPD asked Ms. Parker to write a statement. The officer noted that there were reports in March, April, and May and she was Baker Acted on May 13, 2015 (reference case number: 15-024631). SPD described her statement as "piece meal and some claims appeared to reveal her to be of special interest."

Ms. Parker prepared a lengthy five-and-a-half page written statement that, in part, made allegations against the police, neighbors, and relatives. Allegations against the police included suggestions that: (a) they were flooding Ms. Parker's home with gas and carbon monoxide, (b) they were planning to kidnap her, (c) they would kill her entire family because she is a snitch, and (d) the KKK within the police department ordered her dead.[17]

June 25, 2015: Ms. Parker's cousin, Jesse Ashford, received a video from Ms. Parker that he thought was suspicious and possibly pointing to Ms. Parker being suicidal. He requested a well check on Ms. Parker and L.P. The video received by Mr. Ashford was sent to SPD. The video was Ms. Parker giving a basic will advising what she wanted done with her house and with the care of her daughter if she died.

SPD made repeated attempts to get Ms. Parker to come to the door after which she stated that she had sent the video to numerous family members stating her wishes in case something happened to her. SPD reported that Ms. Parker and L.P. appeared fine.[18]

June 26, 2015: regarding the stabbing incident that gave rise to this claim bill and is described below, Ms. Parker was found guilty on September 23, 2016 of attempted murder and aggravated battery of L.P., and resisting an officer with violence. She is sentenced to 40 years in prison followed by

[16] Claimant's Exhibit 17, *15-024905 Incident Report*, 2 (May 15, 2015).
[17] Claimant's Exhibit 18, *15-027448 Incident Report*, 2 (May 29, 2015).
[18] Claimant's Exhibit 19, *15-032701 Incident Report*, 2 (June 25, 2015).

probation for life with respect to the attempted murder and resisting an officer with violence. She is sentenced to 125.7 months in prison for cruelty toward child-aggravated battery to run concurrent with the 40-year sentence. The court ordered Ms. Parker to have no contact with L.P.[19]

Ms. Parker calls and speaks with S.C. or V.D.C. to ask for money. When she asks about L.P., V.D.C. tells her that L.P. is fine. V.D.C. sends Ms. Parker $30 per month.[20]

History of Abuse Reports with the Department

2009-098932 (June 14, 2009): On June 14, 2009, Ms. Parker filed a police report alleging the paternal aunt intentionally pushed a stroller twice causing the stroller to topple over while L.P. was inside. Hospital records show that Ms. Parker went to the hospital on June 11, 2009, but left a couple of hours after arriving. The hospital reported that Ms. Parker brought L.P. to the hospital on June 9, 2009, with allegations that L.P. rolled off of a chest and hit her head on the concrete floor, causing no known injuries.[21]

2010-016983 (January 29, 2010): The allegations were that about a year ago, Ms. Parker had another child removed from her care and the child was not returned. She now has L.P. in her care and seems to be displaying behaviors that suggest she may be mentally unstable, and it may not be a safe environment for L.P. Ms. Parker reportedly displays erratic behavior. There is an injunction against L.P.'s father for unknown reasons and he is not allowed to have contact with her.

The case closed with "No Indicators of Threatened Harm," it was assessed as "Low to Moderate Risk." It was noted that Ms. Parker and L.P. lived with the maternal grandmother, V.D.C., and there were no safety concerns for the child in the care of Ms. Parker and V.D.C.[22]

2010-210977 (October 13, 2010): The allegations were against the daycare for leaving L.P. and 13 other children unsupervised allowing another child to bite L.P., causing a

[19] *State of Florida v. Ashley Yvonne Parker*, case no. 2015CF10327 (June 29, 2015).
[20] Hearing at 5:23:41-5:24:33.
[21] Department's Composite Exhibit 7, *Intake Report with Reporter Narrative*, (June 14, 2009).
[22] Department's Composite Exhibit 6, *Intake Report with Reporter Narrative*, 3, 7-8 (Jan. 29, 2010).

deep bite to her cheek. The case was closed with "No Indicators."[23]

2013-177775 (June 27, 2013): The allegations were that Ms. Parker refused to allow L.P. to attend a field trip with the daycare and was advised not to bring the child to school but brought her anyway. The mother pushes and screams at L.P. sometimes. The case was closed with "No Indicators of Inadequate Supervision." It was noted that Ms. Parker was uncooperative with the Department.[24]

2015-135492 (May 18, 2015): The allegations in this report are that a child at L.P.'s school had touched her inappropriately. L.P. had been crying and not wanting to go to school. She was examined and "nothing abnormal" had been identified. CPI Munoz was assigned to the case and it was closed with no services with the notation that Ms. Parker has a history with the Department of making false allegations and not cooperating with investigations. It should be noted that besides this report, there was no mention of any other "false allegations" made by Ms. Parker to the Department.[25]

Unreported Abuse

Therapy records indicate that, before the stabbing incident described below, L.P. reported to her therapist that Ms. Parker killed her seven bunnies, tried to drown her in a toilet and bathtub, and tried to poison her with pills. L.P. reported being put in the bathtub and Ms. Parker attempting to drown her two or three times.[26] On November 30, 2018, L.P. Reported to Dr. Forrest that she is afraid of swimming because her mother tried to drown her in the toilet.[27]

The Department Investigation at Issue

On June 25, 2015, at 4:31 p.m., the Department received report number 2015-172495-01 (the "June 2015 report"). A decision was made regarding the intake report on June 25,

[23] Department's Composite Exhibit 5, *Intake Report with Reporter Narrative*, 2, 9 (Oct. 13, 2010).
[24] Department's Composite Exhibit 4, *Intake Report with Reporter Narrative*, 2, 8 (June 27, 2013).
[25] Department's Exhibit 2, *Confidential Assessment Summary Child-on-Child Assessment (without Reporter Information*), 1-2 (May 18, 2015).
[26] Evaluation at pp. 42-43; Hearing at 2:55:00-2:55:25.
[27] Plaintiff's Trial Exhibit 1-6, *Psychotherapy Notes, Office of Dr. Sharon D. Forrest Ed. D, LMFT #2750*, 3 (Feb. 15, 2019); Hearing at 2:55:00-2:55:25.

2015, at 4:48 pm. The reporter was a deputy from SPD. The Hotline assigned the case as an immediate response time.[28]

Allegation Narrative:
On June 25, 2015, law enforcement responded to the home due to a suicide threat. The mother sent a video of her last will and testament stating:

> "…Ashley Yvonne Parker being of sound mind do hereby leave the trust of this house [] to my daughter [L.P.] and the executor of the estate to my mother [V.D.C.] to raise [L.P.] with [S.C.]. In case they can't do it, Kenneth Adams. I leave the house to [L.P.] if and when she does turn 30 years old. I also leave custody to Kenneth if anything was to happen to [V.D.C.] or [S.C.]. Next would be Jessie Ashford Junior, my uncle. And if they can't take care of [L.P.] next would be [Mr. Adams] of West Palm Beach, Florida."[29]

The June 2015 report explained efforts law enforcement had to make to have contact with Ms. Parker, raised concerns about her truthfulness, and raised issues about her mental health and past Baker Act. Law enforcement left L.P. in the care of Ms. Parker and reported they felt that it was a safe environment.

Pre-Commencement Supervisor Consultation
Child Protective Investigator (CPI) Supervisor Tucker and CPI Cheree Lopez completed the required pre-commencement consultation at 7:00 p.m. on June 25, 2015. Notes from the meeting highlight some of the following relevant points: [30]

- Ms. Parker has a history of mental health, and additional information is required on this issue.
- Prior Department reports were reviewed and prior charges for false reports and neglect were known.
- Concerns raised regarding Ms. Parker's willingness to cooperate with child protective services and other agencies.

[28] The Department's Exhibit, *Intake Report with Reporter Narrative*, 1-3 (June 25, 2015) (hereinafter referred to as "June report").
[29] Claimant's Trial Exhibit 74, *Suicide Video 6-25-2015* (June 25, 2025).
[30] Claimant's Trial Exhibit 53, *Pre-Commencement 6-25-2015* (June 25, 2015).

Home Visit on June 25, 2015

CPI Supervisor Tucker and CPI Lopez arrived for a home visit at 7:44 p.m. on June 25, 2015, at Ms. Parker's residence.[31] They were wearing badges and had on shirts that identified them as working for the Department.[32] They approached the residence, knocked on the door, and were greeted by Ms. Parker who stayed behind the door. The door was cracked but it was dark so she could not see inside. Ms. Parker misidentified herself as L.P.'s godmother named Valencia Dubois, so CPI Lopez was asking her questions about Ms. Parker and L.P. all of which were answered positively.[33] CPI Lopez asked Ms. Parker to go inside the house but Ms. Parker refused because she reported she was not dressed.[34] Ms. Parker was laughing and joking around so her tone was not concerning to CPI Lopez.[35]

V.D.C. walked up to the residence after CPI Supervisor Tucker and CPI Lopez arrived when they had been speaking with Ms. Parker.[36] CPI Supervisor Tucker and CPI Lopez were a few feet from the front door.[37] V.D.C. was agitated and reported being in a car accident that day.[38] CPI Supervisor Tucker informed Ms. Parker and V.D.C. who they were and that they were there for an investigation.[39] V.D.C. claimed the report was false.[40] V.D.C. was present when CPI Lopez was speaking with Ms. Parker,[41] but given her hearing deficits it is reasonable to infer that she did not hear the conversation.

V.D.C. indicated that she had power of attorney because Ms. Parker travels back and forth to Orlando, and she showed CPI Supervisor Tucker and CPI Lopez a copy of the power of attorney. CPI Tucker did not read the power of attorney in totality.[42]

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[31] June Report at 3-4.
[32] Hearing at 6:49:40-6:49
[33] *Id.* at 6:44:30-6:45:25; Tucker T-VII 1929: 2-5.
[34] *Id.* at 6:45:45-6:46:11.
[35] *Id.* at 7:32:15-7:33:00.
[36] Hearing at 6:46:11-6:46:32; Tucker T-VII 1983:20-25; 1984: 1-5.
[37] *Id.* at 5:05:07-5:05:21.
[38] *Id.* at 6:45:15-6:45:31.
[39] *Id.* at 6:49:50-6:50:08.
[40] Hearing at 7:35:25-7:35:58; 2015-172495 Chronological Notes Report, 4 (June 26, 2015) (hereinafter referred to as "Chronological Notes").
[41] Hearing at 6:46:32-6:46:59. 5:05:39-5:05:53.
[42] Tucker T-VII 1923: 22-25; 1925: 21-25; 1926: 1-7; Lopez T-IV 1035: 14-21; V.D.C. T-VI 1691: 11-13.

Conflicting testimony and evidence regarding where Ms. Parker reportedly was located when CPI Supervisor Tucker and CPI Lopez were at Ms. Parker's residence was offered in discovery and hearing testimony. CPI Supervisor Tucker and CPI Lopez suggested that V.D.C. informed them that Ms. Parker was in Orlando and V.D.C.'s testimony that she informed them Ms. Parker was in the house. [43] However, Chronological Notes entered the day after the home visit on June 26, 2015, at 3:17 p.m., which the undersigned finds more credible, suggests that "CPI [Lopez] was unable to get contact and whereabouts information regarding the mother from either the maternal grandmother [V.D.C.] or the Godmother [Ms. Parker]."[44]

CPI Supervisor Tucker and CPI Lopez asked to speak with L.P.[45] V.D.C. went inside to get L.P. and they went back outside together.[46] L.P. presented very well cared for and clean with her hair done and wearing matching clothes.[47] The CPI Supervisor asked about several topics: school, activities, her appearance, and living at home[48] for approximately 30 minutes.[49] L.P. did not express any concerns about Ms. Parker and did not appear scared.[50]

When CPI Supervisor Tucker and CPI Lopez were leaving, V.D.C. and L.P. went to the door to go inside but it was locked. V.D.C. knocked on the door three times and she said, "Ashley open the door, Ashley open the door, open the door Ashley."[51] They were in the yard but starting to go down the road[52] so they would not have heard her call Ms. Parker's name.

After CPI Supervisor Tucker and CPI Lopez left and V.D.C. went inside, she asked Ms. Parker what if anything she told them. Ms. Parker told V.D.C. that she used a different name and V.D.C. yelled at her for not using her correct name.[53] V.D.C. and S.C. testified that Ms. Parker was reportedly acting

[43] Hearing at 5:06:07-5:06:34; 6:47:00-6:47:20; 6:49:05-6:49:24; Tucker T-VII 1920: 19-25.
[44] Chronological Notes at 4.
[45] Hearing at 5:03:00-5:03:16.
[46] *Id.* at 5:05:21-5:05:39.
[47] *Id.* 6:48:22-6:49:00.
[48] *Id.* at 5:05:39-5:05:53; 7:34:30-7:35:25.
[49] Hearing at 5:07:55-5:08:00.
[50] *Id.* at 5:07:20-5:07:36.
[51] *Id.* at 5:11:35-5:12:03.
[52] *Id.* at 5:12:07-5:12:24.
[53] Hearing at 5:17:00-5:18:00.

normal on this night,[54] and Ms. Parker gave them no indication that she was going to stab L.P. the next day.[55]

Stabbing Incident on June 26, 2015

On the morning of June 26, 2015, V.D.C., S.C., Ms. Parker, and L.P. ran errands.[56] Then, V.D.C. and S.C. dropped off Ms. Parker and L.P. at the house.[57] S.C. had no concerns for L.P.'s safety when leaving her with Ms. Parker.[58] Ms. Parker wouldn't let L.P. go to the store with V.D.C. and S.C.[59] S.C. did not see a knife and denies that L.P. asked him not to leave the house.[60]

L.P. reported to her therapist that, while V.D.C. and S.C. were gone, she was placed fully clothed in a filled bathtub, inverted, and that she could not breathe and reported feeling "my heart stop."[61] She also reported having an unknown substance in her mouth.[62] According to police reports who later responded to the scene, there was a strong odor of chemicals and the bathtub was half full of water.[63]

After Ms. Parker attempted to drown L.P., Ms. Parker was pacing back and forth and speaking out loud. She laid L.P. on the bed, started scratching L.P.'s back with her nails and then began to stab her. L.P. described to Dr. Forrest the pain she felt when she was being stabbed and how she tried to stop Ms. Parker from stabbing her in the shoulder which resulted in her stabbing the bed. Then Ms. Parker turned L.P. over and cut open her stomach which resulted in her intestines coming out (the "stabbing incident"). L.P. reports "slithering" down the hallway to get away from Ms. Parker. [64]

V.D.C. and S.C. were gone for about an hour.[65] When V.D.C. and S.C. arrived back at the house, they could not get inside

[54] *Id.* at 5:18:10-5:18:25.
[55] *Id.* at 2:22:00-2:22:20; 2:23:45-2:24:00; 2:26:55-2:27:15.
[56] *Id.* at 2:24:00-2:24:50; 2:22:35-2:22:45.
[57] Hearing at 2:24:50-2:25:13.
[58] *Id.* at 2:27:42-2:28:02.
[59] *Id.* at 2:49:17-2:49:28.
[60] *Id.* at 2:49:30-2:50:22.
[61] Evaluation at 30.
[62] *Id.*
[63] *Id.* at 14.
[64] *Id.* at 42.
[65] Hearing at 2:54:00-2:54:21.

because V.D.C.'s key would not open the door.[66] This was unusual because the key usually worked, and she had been able to use it recently.[67] V.D.C. knocked on the front and back doors yelling for Ms. Parker to open the door.[68] When Ms. Parker opened the door, she had a long butcher knife in her hand and told them that somebody broke in the house.[69] S.C. looked at the lock and saw that there was no damage. He said "If somebody broke in the house, where is the baby?"[70]

S.C. went looking for L.P. and found her cuddled up under a blanket.[71] S.C. said, "Baby, let's go" and L.P. said "Pop, pop."[72] S.C. looked down, said, "Oh my God." He called 911.[73] He asked L.P. who hurt her, and she replied, "Mommy."[74]

Sarasota County Fire Department arrived on scene, administered emergency care, and transported L.P. to Sarasota Memorial Hospital.[75] Dr. Ali Al-Rawi is a trauma and critical care surgeon and Dr. Russell Jaicks is a trauma surgeon at Sarasota Memorial Hospital.[76] Both surgeons treated L.P. on June 25, 2015.[77] L.P. was intubated, and a CT scan was performed.[78] L.P. was put under general anesthetic.[79] She had a total of 14 stab wounds,[80] including a laceration to the bowl and colon and contamination of the abdomen.[81] Dr. Al-Rawi and Dr. Jaicks performed procedures, such as stapling the lacerations, to stop the bleeding and leakage.[82] L.P. was transported to Johns Hopkins All Children's Hospital (JHACH) once she was stable on June 26, 2015, where she received care until July 6, 2015, when she was discharged.[83]

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[66] *Id.* at 2:25:20-2:25:48.
[67] *Id.* at 2:54:00-2:54:21.
[68] *Id.* at 2:25:50-2:26:06.
[69] Hearing at 2:26:07-2:26:28.
[70] *Id.* at 2:26:28-2:26:41.
[71] *Id.* at 2:56:00-2:56:32.
[72] *Id.* at 2:56:32-2:56:50.
[73] Hearing at 2:56:50-2:56:56.
[74] S.C. T-V 1404: 4-7.
[75] Claimant's Exhibit 1-8, *Sarasota County Fire Department-19993*, 4-5 (June 25, 2015).
[76] Al-Rawi T-III 693:2-3; Jaicks T-III 626: 11-12.
[77] Al-Rawi T-III 697: 13-18.
[78] *Id.* at 701: 15-16; 702: 3.
[79] *Id.* at 703:2-4.
[80] *Id.* at 703: 21.
[81] Al-Rawi T-III 705: 2-5.
[82] *Id.* at 704: 6-22; 706: 3-25; 707: 1-15.
[83] *Id.* at 697: 8-12; Claimant's Exhibit 1-7, *Johns Hopkins All Children's Hospital*, 1 (June 26, 2015).

Damages

V.D.C. testified that L.P.'s mind reverted to an infant after the stabbing incident, and she still does things that a three- or four-year-old does,[84] such as playing with toys in the bathtub.[85] L.P. sees a psychiatrist every three months.[86] L.P. has anxiety and she takes Adderall.[87] Dr. Forrest, L.P.'s treating licensed marriage and family counselor, reported L.P. has post-traumatic stress disorder from the stabbing incident.[88] In the past, S.C. has witnessed L.P. awake in the middle of the night appearing to "make believe talking to someone,"[89] and expressed concern because Ms. Parker, who is diagnosed with multiple personality disorder, started acting the same way on ADHD medication around the same age.[90] On April 12, 2019, V.D.C. and S.C. informed Dr. Forrest that L.P. has angry conversations out loud with Ms. Parker while Ms. Parker is not actually present.[91]

L.P. was practicing gymnastics for eight years, but she stopped this year because she reports that sometimes her stomach hurts.[92] L.P. cries often, has nightmares[93] and does not like her hair washed because Ms. Parker tried to drown her.[94] She is very frightened of the bathtub and afraid of drowning.[95] L.P. struggles to take responsibility for things, such as chores, but V.D.C. acknowledged that this may be L.P. being a normal teenager.[96] On January 14, 2021, Dr. Sheshani quoted, "She does something, and then blames it on 'Little [].'"[97]

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[84] Hearing at 4:46:05-4:46:20.
[85] *Id.* at 5:27:00-5:27:50.
[86] *Id.* at 2:19:15-2:19:29.
[87] *Id.* at 2:42:30-2:43:00.
[88] Evaluation at 14.
[89] *Id.* at 44.
[90] *Id.* at 50.
[91] *Id.* at 40.
[92] Hearing at 4:49:30-4:49:39; 2:13:30-2:14:10.
[93] *Id.* at 2:14:10-2:15:15.
[94] *Id.* at 2:15:30-2:15:48.
[95] Evaluation at 44.
[96] Hearing at 5:34:00-5:35:00.
[97] Evaluation at 54.

Evaluation

Dr. Michael Shahnasarian[98] prepared a Vocational Rehabilitation Evaluation of L.P. dated August 30, 2021 (the "evaluation"). The Careys reported L.P. experiences the following problems that Ms. Carey reported she did not experience before her attempted murder in June 2015:[99]

- Scarring on abdomen, lower extremities, and back secondary to stabbing injuries
- Complaints of abdominal pain
- Complaints of nightmares
- Apprehensive/fear reaction to being touched and to receiving medical care
- Attentional difficulties and hypervigilance
- Emotional lability
- Trouble with organization and initiation
- Impaired social relations
- Impaired scholastic performance
- Impaired self-care and independence skills
- Impaired memory

Dr. Shahnasarian conducted several tests with respect to the evaluation of L.P. which are summarized below:[100]

- Test of cognitive ability of her intellectual skills and abilities - scored in the 39th percentile for her age group.
- Test of basic skills:
  - Reading – Grade 4.4
  - Spelling – Grade 3.9
  - Arithmetic – Grade 5.1
- Test measuring levels of her self-esteem resulted in her general and global being low, and her social self-esteem being very low.
- Children's Depression Inventory – total score was 16 (Slightly above average range)

L.P. was in the sixth grade, after having repeated the third grade, at the time of the test.

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[98] *Id.* at 2-4 (Aug. 30, 2021) (Dr. Michael Shahnasarian, who founded and works for Career Consultants of America, Inc., is a licensed psychologist who has three degrees in psychology, including a Ph.D. in counseling psychology from Florida State University. He specializes in rehabilitation psychology and subspeciality in life care planning and vocational rehabilitation. Dr. Shahnasarian has a lengthy resume of credentials that support his expertise in these areas).
[99] *Id.* at 2.
[100] *Id.* at 57-58.

Dr. Shahnasarian's opinions are based on a reasonable degree of vocational assessment and rehabilitation certainty.[101] When he interviewed L.P., she was in a special school for children with special needs. She had an individualized education plan which extended several accommodations for her, such as three days to take a test.[102] She was having a lot of issues at that time including mental health issues, such as having anxiety and disability adjustment issues in many areas. She was delayed socially which was evident in his testing. [103] L.P. had difficulty making friends at school and she does not form social bonds.[104]

When questioned about how the life plan may be impacted given L.P.'s testimony that she hangs out with friends on the weekend signifying some ability to form bonds, Dr. Shahnasarian explained that he would expect there to be some changes/minor variances (e.g. change in medication or child forming friendships) but the life care plan in total provides a very good blueprint of what Dr. Shahnasarian expects to see with respect to L.P.'s needs.[105] Despite this opinion, the life care plan provides for several updated life care plans at various intervals of L.P.'s life.[106]

In summary, Dr. Shahnasarian's opinion regarding L.P.'s vocational capacity are that, without intensive intervention, she would not be able to pursue even unskilled employment that offers the minimum wage rate. She has a number of vocational handicaps that would likely further erode her earning capacity by 70 percent to 80 percent that she would have under a best case scenario, such as diminished access to work opportunities, need for accommodations, likelihood of absences from the workplace during periods of symptom exacerbation, employer bias, and vulnerabilities to reductions in force.[107] Dr. Shahnasarian noted that L.P. is receiving extraordinary accommodations in school that might not be extended to her in the workplace.[108] Dr. Shahnasarian opined that the social, emotional, and psychological problems she

[101] Hearing at 3:22:26-3:22:50.
[102] *Id.* at 2:34:30-2:35:00; 4:46:48-4:47:30.
[103] *Id.* at 3:11:42-3:14:51.
[104] *Id.* at 3:52:00-3:54:10.
[105] Hearing 3:52:00-3:54:10.
[106] Plaintiff's Trial Exhibit 78, Shahnasarian, M. *1st Update Life Care Plan Prepared for L.X.C.*, 6 (Feb. 14, 2022) (hereinafter referred to as "Life Care Plan")
[107] Hearing at 3:11:42-3:14:51.
[108] *Id.* at 3:19:30-3:19:51.

was experiencing at the time are likely to persist as they had been to date.[109]

Life Plan

Dr. Shahnasarian prepared a life care plan for L.P. dated February 14, 2022 (the "life care plan").[110] A life care plan identifies current and future rehabilitation interventions that are probable given the trauma that L.P. has acquired.[111] The life care plan consists of several costs that L.P. is expected to or may incur throughout her life as a result of the stabbing incident,[112] including: residential care options, evaluations, therapeutic needs, aids for independent living, drug and supply needs, home/facility care, educational needs, procedures, and potential complications.[113] Dr. Shahnasarian's opinions set forth in the life care plan are held within a reasonable degree of life care plan certainty.[114]

Life care plans are created based on fair market value. There are no discounts or negotiated collateral offsets to the life care costs, such as health insurance.[115] They do not take into account any potential outside sources for programs that may be available to L.P., such as state paid tuition.[116]

The life care plan sets out three residency options:[117]

1. Option A: Live in attendant from age 18 – 21 to life, 7 days per week, 365 days per year.
2. Option B: Attendant care/companion services from age 18-21 to life, the frequency is to be determined.
3. Option C: Independent living with case management from age 18-21 to life.

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[109] *Id.* at 3:20:00-3:20:46.
[110] *Id.* at 3:45:45-3:47:17 (Dr. Shahnasarian noting that the last time he saw L.P. face-to-face was in August 2021. He has not received any updated recommendations and reports on L.P.'s progress since that time except for consultations with contributors to the life care plan noted on page 3 of the report in September 2021. Dr. Shahnasarian would not be surprised if there are any changes either for the better or the worse but, materially in terms of her overall level of damages and vocational ability, he would be very surprised if there are any changes).
[111] Hearing at 3:22:00-3:22:26; 3:22:50- 3:23:11.
[112] *Id.* at 3:43:08-3:43:29.
[113] Life Care Plan at 5-14. The life care plan notes that, "Year 1 in the duration section of this life care plan begins on the date this life care plan is published." *Id.* at 3.
[114] Hearing at 3:43:29-3:43:39.
[115] *Id.* at 3:47:48-3:48:03.
[116] *Id.* at 3:48:03-3:48:13.
[117] Life Care Plan at 5.

Dr. Shahnasarian's report notes that "Per Dr. Forrest, it is unlikely L.X.C. will be capable of independent living." Dr. Shahnasarian testified that L.P. is most likely to require option A with a live in attendant.[118] He reached this opinion based upon standards required of certified life care plan specialists.[119] When questioned about the kind of activities Dr. Shahnasarian thinks L.P. is unable to do to take care of herself, he relied on her activities of daily living in his report, such as concerns she needs prompting to tie her shoes or comb her hair requiring supervision,[120] and an gave example about L.P. experiencing a lot of anxiety so things like her going out in public and being able to shop for her anticipated grocery needs on her own.[121] Dr. Shahnasarian testified that option C is the least likely scenario.[122] He does not consider option C is likely at all but he included it for consideration.[123]

Three types of evaluations are recommended as follows:[124]

- A cosmetic surgeon evaluation to determine whether the remaining scars on her legs and abdomen can be revised and what would be the nature of the procedure.[125]
- A neuropsychological evaluation to address her cognitive status.[126]
- Updated life care plans with a cost of $7,000 for each update. Updated life care plans are recommended including one between the ages of 17 and 22 as she nears or enters adulthood, and three between the age of 30 and the remainder of her life at 10 year intervals.[127]

Several therapeutic needs are anticipated, including:[128]

- Psychiatrist follow up for one session per month for the first year, followed by one session every three months for the remainder of her life.[129]
- Psychological counseling required to supplement psychiatric treatment on a graduated schedule.

[118] Hearing 3:26:15-3:28:05.
[119] *Id.*
[120] Evaluation at 11-12.
[121] Hearing at 4:02:30-
[122] *Id.* at 3:28:05-3:28:35.
[123] *Id.* at 3:54:10-3:56:00.
[124] Life Care Plan at 6.
[125] Hearing at 3:30:00-3:30:32.
[126] *Id.* at 3:30:32-3:30:50.
[127] Life Care Plan at 6.
[128] *Id.* at 3.
[129] Hearing at 3:33:00-3:33:54.

- Group counseling: to be determined.[130]
- Family counseling from year one to age 21 for six to 12 sessions per year.[131] L.P. is not currently engaged in any family counseling.[132]
- Hairdresser from years one to five once every two weeks at a cost of $55-$130 each visit.[133] Dr. Shahnasarian testified that the cost for a hairdresser included in the life plan is not a luxury item. Ms. Carey described the extreme difficulty Ms. Carey has had getting L.P. to wash her own hair or even worse when Ms. Carey attempts to wash L.P.'s hair. L.P. was responding to a hairdresser washing and fixing her hair.

Aids for independent living included in the life care plan are:[134]

- Emotional support animal, which is of no charge.[135]
- Miscellaneous adaptive aids/patient education from year one for life at a cost of $1,200 per year for items such as security system/devices and topical creams for scars.

With respect to drug and supply needs, Dr. Sheshani recommended Folcalin XR (Dexmethylphenidate ER) 10 mg, which has been replaced with an Adderall prescription.[136] The life care plan anticipates L.P. taking one tablet per day at a cost of $408.59-$567.99 per 30 tablets.[137] L.P. currently has medical insurance through the Department. [138] The life care plan includes SSRI medications to address anxiety that is to be determined.[139]

Three home/facility care services are recommended in the life care plan, including:[140]

- Housekeeper with a cost of $125-$150 per visit but the duration and frequency is to be determined.
- Option A and B: Case manager beginning year one for life for two to three hours per month at a cost of $110 per hour.

[130] *Id.*
[131] Life Care Plan at 7.
[132] Hearing at 3:48:13-3:49:21.
[133] Life Care Plan at 7.
[134] Life Care Plan at 9.
[135] Hearing at 3:36:50-3:37:21.
[136] Evaluation at 10.
[137] Life Care Plan at 10.
[138] Hearing at 3:48:17-3:48:40.
[139] Life Care Plan at 10.
[140] *Id.* at 11.

- Guardian beginning age 18-21 for life for one to two hours per month at a cost of $95 per hour.

Several recommendations were made with respect to L.P.'s educational needs, including: [141]

- Private school placement from year one to grade eight at $15,750 per year and grade nine to grade 12 at $14,000 per year. The life care plan does not take into consideration sources for children who have been in out of home placement such as scholarships that might be available for use at private schools.[142]
- Tutorial assistance at a cost of $60 per hour from year one to year eight at five-eight hours per week and year nine to 12 at 10-12 hours per week. V.D.C. testified that L.P. received tutoring when she was younger, but she is not receiving it now.[143]
- Vocational guide services one time between age 17 to 22 at a cost of $5,000 to $7,000.
- Life skills coach for four to six hours per week at a cost of $60 per hour from year one to age 21. Dr. Shahnasarian testified that a life skills coach would facilitate her ability to perform self-care activities and develop more adaptive activities of daily living skills but not to the point where she would be able to completely live independently.[144] L.P. has not begun receiving these services.[145]

Dr. Shahnasarian opined it is not within a reasonable degree of vocational rehabilitation certainty that L.P. could attend a mainstream college like the University of South Florida (USF) without any accommodations. He thinks L.P. is lacking insight into her deficits if her testimony is that she wants to attend USF. [146]

Dr. Patti, a plastic surgeon, recommends procedures that include laser regimens, scar revisions between age 18 to 21 as needed at a minimum cost of $25,000.[147]

[141] *Id.* at 12.
[142] Hearing at 3:47:17-3:48:16.
[143] *Id.* at 4:45:40-4:46:05.
[144] *Id.* at 4:02:50-4:04:50.
[145] Hearing at 4:08:10-4:09:01.
[146] *Id.* at 3:58:05-3:59:28.
[147] Life Care Plan at 12.

Dr. Shahnasarian and Dr. Forrest opine that L.P. is at a greater risk of multiple inpatient psychiatric hospitalizations given, for instance, her trauma, impaired growth, and issues establishing bonds.[148]

Economic Damages

Brenda Mulder and Kristi Kirby prepared an Analysis of Economic Damages re: L.X.C. (Minor) dated February 15, 2022 (the "economic damages report").[149] Their conclusions are summarized below:

- Total economic damages June 26, 2015, to February 28, 2022: $30,248.33

Time Period of Future Economic Damages	
Ms. L.X.C.'s Work Life to Age 67:	49 years (from 6/1/27: Age 18)
Ms. L.X.C.'s Work Life to Age 67	45 years (from 5/21/34: Age 25)
Ms. L.X.C. Life Expectancy	66.9 years (2018 Data – B. Female)

- Present value of lifetime earning capacity: high school graduate: $30,325 annual basis; present value to age 67: $1,170,184 to $1,905,466.
- Present value of lifetime earning capacity: associate degree: $36,950 annual basis; present value to age 67: $1,262,142 to $1,916,929.
- Potential offset for residual earning capacity: minimum wage: present value to age 67: ($300,987) to ($490,112).
- Present value of future medical expenses: $7,932,170 to $14,002,766. A significant portion of the future medical expenses is the live-in attendant for life beginning at age 18 to 21 which totals $6,579,413 to $11,976,608 with an average annual cost of $146,000.

[148] Hearing at 4:18:11-4:22:59.
[149] Plaintiff's Trial Exhibit 79, Mulder & Kirby Economists, Inc., *Analysis of Economic Damages Re: L.X.C. (Minor)* (February 15, 2022) (hereinafter referred to as "Economic Damages Report").

Civil Jury Verdict

On March 11, 2022, the jury rendered the following verdict on damages:[150]

> What is the total amount of Plaintiff, L.X.C.'s damages incurred in the past as a result of the June 26, 2015, incident for medical expenses? *$30,248.33*
>
> What is the total amount of Plaintiff, L.X.C.'s future medical expenses to be incurred over future years as a result of the June 26, 2015, incident reduced to present value? *$14,002,766*
>
> What is the total amount of Plaintiff, L.X.C.'s future loss of earnings capacity to be incurred over future years as a result of the June 26, 2015, incident reduced to present value? *$1,500,000*
>
> Please state the amount of damages incurred by Plaintiff, L.X.C. as a result of the June 26, 2015 incident for pain, suffering, disability, disfigurement, mental anguish, inconvenience and/or loss of capacity for the enjoyment of life:
> In the past? $*4,155,661.60*
> In the future? *$8,311,323.87*
>
> What are the total damages of Plaintiff, L.X.C.? *$28,000,000*

LITIGATION HISTORY:

On May 15, 2017, V.D.C. and S.C. filed a complaint against the Department in the Circuit Court of the Twelfth Judicial Circuit on behalf of the minor L.X.C. (referred to in the claim bill as L.P.). The complaint alleged negligence on the part of the Department through its CPIs when they conducted a Pre-Commencement Meeting at the Department's Sarasota Offices and subsequent home visit/investigation into L.P.'s mother on June 25, 2015, and failed to implement a safety plan thereby causing L.P.'s mother to stab her 14 times the following morning. A jury verdict was rendered on March 11,

[150] *V.D.C. and S.C., on behalf of L.X.C., a minor v. Department of Children and Families*, 2017 CA 2405 NC (Mar. 11, 2022).

2022, which was 100% in favor of the claimant in the amount of $28,000,000.00.

A final judgment was entered in favor of Claimants on April 7, 2022. The Department then appealed to the Second District Court of Appeal. The decision for the claimant was affirmed by the appellate court *per curiam* on September 15, 2023. Thus, all administrative and/or other remedies have been exhausted. The Department has since paid the statutory cap of $200,000 all of which has gone to Claimant's counsel.

CONCLUSIONS OF LAW:

The claim bill hearing was a *de novo* proceeding for the purpose of determining, based on the evidence presented to the special master, whether the Department is liable in negligence for the injuries suffered by L.P.

The claimant must prove four elements for a negligence claim under Florida law, namely: (1) duty of care, (2) breach of care, (3) proximate causation, and (4) damages.[151]

Duty of Care

Whether a duty of care exists is a matter of law.[152] Where the "express intention of the legislature is to protect a class of individuals from a particularized harm, the governmental entity entrusted with the protection owes a duty to individuals within the class."[153] Section 39.001(1)(a), of the Florida Statutes, provides that one purpose of the chapter is "[t]o prevent the occurrence of child abuse, neglect and abandonment." Thus, chapter 39, of the Florida Statutes, designates children as a protected class of individuals from abuse, neglect and abandonment, and the Department as the entity entrusted with the protection of such children owes them a duty of care. The Florida Legislature reinforced the Department's duty in the provisions that: (a) require reporting child abuse to protect children,[154] and (b) in part III, chapter

[151] *Limones v. School Dist. of Lee County*, 161 So. 3d 384, 389 (Fla. 2015).
[152] *McCain v. Fla. Power Corp.*, 593 So. 2d 500, 502 (Fla. 1992).
[153] *Dept. of Health and Rehabilitative Svcs. v. Yamuni*, 498 So. 2d 441, 442-43 (Fla. 3d DCA 1986) (noting that the child was a member of the class protected under a specific statute and the [Department of Health and Rehabilitative Services] owed a statutory duty to protect him from abuse and neglect) (affirmed by *Department of Health and Rehabilitative Svcs v. Yamuni*, 529 So.2d 258 (Fla. 1988)).
[154] Section 39.201, F.S.

39, of the Florida Statutes, that set out the Department's requirements for protective investigations.[155]

"HRS [the Department of Health and Rehabilitative Services, a precursor to the Department] is not merely a police agency and its relationship with an abused child is far more than that of a police agency to the victim of a crime…[T]he primary duty of HRS is to immediately prevent any further harm to the child and that the relationship established between HRS and the abused child is a very special one."[156] The Department has a duty to adequately and reasonably investigate complaints of child abuse, abandonment or neglect.[157]

The Florida Supreme Court opined that "as the risk grows greater, so does the duty, because the risk to be perceived defines the duty that must be undertaken…each defendant who creates a risk is required to exercise prudent foresight whenever others may be injured as a result. This requirement of reasonable, general foresight is the core of the duty element."[158] The Court held that the defendant had "a duty to take reasonable actions to prevent the general type of injury that occurred" in the case.[159]

Therefore, the Department had a duty to protect L.P. from abuse, abandonment, neglect, including any future harm, and a duty to adequately and reasonably investigate the allegations of inadequate supervision.

Breach of Duty

The U.S. Supreme Court held "[w]hat usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not."[160] A fact finder must decide whether a defendant exercised the degree of care that an ordinarily prudent person, or CPI in this instance, would have under the same or similar circumstances.[161] While any

[155] *See* s. 39.301(8), F.S.
[156] *Dept. of Health and Rehabilitative Svcs. v. Yamuni,* 529 So. 2d 258, 261 (Fla. 1988).
[157] *Dept. of Children and Family Svcs. v. Amora*, 944 So. 2d 431 (Fla. 4th DCA 2006).
[158] *McCain*, 593 So. 2d at 503.
[159] *Id.* at 502.
[160] *Texas & Pacific Railway Co. v. Behymer*, 189 U.S. 468, 470 (1903).
[161] *Russel v. Jacksonville Gas Corp.*, 117 So. 2d 29, 32 (Fla 1st DCA 1960) (defining negligence as, "the doing of something that a reasonable and prudent person would not ordinarily have done under the same or similar

applicable laws set baseline requirements, the reasonably prudent CPI standard can impose a higher duty so a party who complies with a regulation, if any, does not automatically absolve a party from liability if additional precautions would have been reasonable.[162]

The Claimant submits that the Department has breached its duties in this case, such as duties to:

- Check for local law enforcement call outs before the home visit,
- Speak to the mandatory reporter before the home visit,
- Respond to Ms. Parker's home within two hours for the initial home visit,
- Properly assess present and impending danger, and
- Implement a safety plan, including supervised visitation with the mother.

The Department responds by arguing that it was either not required by law (e.g. to obtain local police reports or contact the reporter before the home visit)[163] or not authorized by law to perform the duties (e.g. implement a safety plan without present or impending danger) for which the Claimant alleges it has breached. However, case law establishes a reasonably prudent CPI standard, not solely whether the law has been complied with, that determines whether a defendant has breached its duty.

Pre-commencement Phase

For the reasons summarized below, a reasonably prudent CPI would have taken additional reasonable efforts to obtain the call outs and contact the reporter. The Department faxed a request for prior police reports to the SPD after L.P. was stabbed.[164] Although CPI Lopez testified and evidence suggests that she contacted Officer Tschetter, Officer Kennedy, and Mr. Ashford at 6:21 pm, 6:22 p.m., and 6:24 p.m., respectively,[165] Officer Tschetter testified at the trial,[166]

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circumstances, or the failure to do that which a reasonable and prudent person would have done under the same or similar circumstances").

[162] *McCain*, 593 So. 2d at 503 (noting that foreseeability of harm determines the scope of the duty); *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932) (Judge Learned Hand held a tugboat owner negligent for failing to equip a vessel with radios, even though there were no legal requirements to do so, because a reasonable operator would have taken that precaution.).

[163] Sections 39.301(6), and (9)(a)1., F.S.; Rule 65C-29.009(1), F.A.C.

[164] Tucker T-VII 1884: 18-20.

[165] Chronological Notes at 1-3.

[166] Tschetter T-II 363: 20-22.

and he and Officer Kennedy testified at the claim bill hearing,[167] that they did not receive calls or voicemails from CPI Lopez. Officer Kennedy testified that there were several ways that CPI Lopez could have contacted him on June 25, 2015, such as calling dispatch or the front desk.[168]

If CPI Lopez had spoken with Officer Tschetter, he could have provided her with a copy of the video and concerns that Ms. Parker's cousin, Mr. Ashford, had presented to him. With respect to the Baker Act that occurred in May 2015, Officer Tschetter could have informed CPI Lopez about the fact that Ms. Parker had been Baker Acted. Also, he could have pulled up the report to explain why Ms. Parker had been contacted and why she had been Baker Acted but he did not have access to the Baker Act form. He would not have been able to inform CPI Lopez of the Baker Act's disposition but simply that she had been Baker Acted and what facility she was taken to if that information was in the report.[169] He also could have retrieved the prior police reports that had been uploaded to the reporting system and informed CPI Lopez of their content.[170]

The Department failed to gather adequate collateral information and instead relied on: (a) Ms. Parker's lies when CPI Supervisor Tucker and CPI Lopez received information from Ms. Parker as L.P.'s purported godmother and (b) representations made by V.D.C., who had a history of denying Ms. Parker's suicidal ideations.[171] Had CPI Supervisor Tucker or CPI Lopez requested the police reports or made contact with the reporter, they would have relevant and important information regarding Ms. Parker's mental health issues, such as the information contained in the letter attached to the police report dated May 29, 2015, and Officer Tschetter's explanation of his previous encounter with Ms. Parker. In these circumstances, a reasonably prudent person would have obtained additional collateral information before conducting the home visit.

[167] Hearing at 23:30-24:50; 36:00-36:50.
[168] *Id.* at 43:30-43:43.
[169] *Id.* 52:00-53:34.
[170] *Id.* at 53.34-53:57; 1:03:40-1:04:03.
[171] Callouts at 9 (V.D.C. averring Ms. Parker was not suicidal).

Home Visit

For the reasons summarized below, a reasonable prudent CPI would have taken the following steps:

- Responded to the home within two (2) hours,
- Confirmed Ms. Parker's identity,
- Requested law enforcement assistance,
- Conducted adequate interviews, and
- Implemented a safety plan with supervised visitation.

Response Time

On the date of the June 2015 report, the Florida Administrative Code defined "immediate" or "immediately" to mean as soon as possible, but no later than two (2) hour timeframe.[172] However, the Department relies on its Safety Methodology Practice Guidelines, Investigations (the "Guidelines"), which was in effect on June 25, 2015, that provides a report requiring an immediate response time "requires the investigator to attempt to make the initial face-to-face contact with the alleged child victim as soon as possible but no later than four (4) hours following assignment by the Hotline.[173] The Florida Administrative Code contains rules which are binding whereas the Department's Guidelines are not.

The Department received the June 2015 report at 4:31 pm and the decision time was 4:48 pm. CPI Lopez testified that the response time is calculated from the time the decision has been made.[174] which means that the CPI would have to be at the home visit no later than 6:48 pm under the two (2) hour maximum time limit in Rule 65c-30.001(65), of the Florida Administrative Code. According to Chronological Notes, the home visit began at 7:44 pm, which is almost three (3) hours after the June 2015 decision time and approximately one (1) hour after the maximum time for which the home visit was required to begin.

If CPI Supervisor Tucker and CPI Lopez had arrived at Ms. Parker's residence within two (2) hour, V.D.C. would not have been present and they would not have been able to rely on her representations as a collateral source in the first instance.

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[172] Rule 65C-30.001(65), F.A.C. (2015); This Rule was amended effective February 25, 2016, after the date of the June 2015 report, to change the maximum response time from two (2) hours to four (4) hours.
[173] Plaintiff's Trial Exhibit 92, *Safety Methodology Practice Guidelines, Investigations*, p. 9 (Aug. 8, 2014).
[174] Lopez T-IV 830: 1-3.

Evidence suggests that V.D.C. had to go inside of the house to get L.P. to meet CPI Supervisor Tucker and CPI Lopez outside. If V.D.C. was not there at the time of the home visit and Ms. Parker refused to open the door, as she had done on June 25, 2015, a reasonably prudent CPI would have called law enforcement to be able to observe and speak with L.P. and, if Officer Tschetter and Kennedy responded as they testified they would, then law enforcement would have been able to identify Ms. Parker.

Identifying Ms. Parker

Regardless of whether CPI Supervisor Tucker and CPI Lopez had responded within two (2) hours, a reasonably prudent CPI would have taken additional steps to confirm Ms. Parker's identity. Indeed, on a prior occasion, CPI Munoz relied upon a Driver and Vehicle Identification Database (DAVID) image of Ms. Parker when she reported to her residence for an earlier abuse report.[175] A reasonably prudent CPI would take this or a similar step, such as asking L.P. where her mother is located, given Ms. Parker's history of false reports.[176]

Request Law Enforcement Assistance

A reasonably prudent CPI would have called law enforcement for assistance, especially if V.D.C. had not been present if the CPI Supervisor Tucker and CPI Lopez had arrived within two (2) hours. Given Ms. Parker's history of lies and uncooperativeness and that the police were there hours earlier and met with her, there should have been a suspicion the person behind the door was Ms. Parker. Officer Tschetter testified that law enforcement is available to assist the Department if a person in the home would not identify herself and would have done so in this case if he had received a call.[177] All the Department had to do was make the call to request the assistance and it should have done so in these circumstances.

Adequate Interviews

A reasonably prudent CPI would have interviewed V.D.C. and L.P. separately and asked additional relevant questions to gain a greater understanding of the totality of the

[175] Munoz T-II 452:18-25; 453: 1-15.
[176] Callouts at 9 (V.D.C. averring Ms. Parker was not suicidal). Similarly, on Jun. 25, 2015, V.D.C. reported to the Department that the report made earlier that day was false. Hearing at 7:35:25-7:35:58; 2015-172495; Chronological Notes at 4.
[177] *Id.* at 24:50-25:35.

circumstances. The Department's policy is "[W]ith few exceptions, household members should be interviewed separately in the home when possible, in the following order, using information gathered from one interview to assist in the development of questions for the next interview:

(1) Identified child victim.
(2) Siblings or other children in the household.
(3) Non-maltreating parents and caregivers, including all adult household members.
(4) Other parent (as a collateral contact when parent no longer lives in the same household).
(5) Maltreating parent/caregiver.[178]

The facts of this claim bill are not one of the exceptions that would warrant interviewing witnesses in front of each other. V.D.C. was claiming the report was false, which may have influenced L.P.'s willingness to report any harm caused by Ms. Parker. For these reasons, CPI Supervisor Tucker and CPI Lopez should have interviewed L.P. separately.

Further, the evidence presented suggests that the Department should have asked additional questions on the following topics:

- Question all witnesses as to where Ms. Parker was on June 25, 2015.[179] To the extent V.D.C. may have suggested Ms. Parker was in Orlando, details regarding her trip should have been sought since law enforcement was at the home and met with Ms. Parker several hours earlier (e.g. questions like: when did she leave to go to Orlando, how long she would be there, and when she would be home?).[180]
- V.D.C. and Valencia Dubois (i.e. Ms. Parker) regarding Ms. Parker's mental health history (e.g. prior Baker Acts and suicide threats).[181]
- L.P. regarding whether Ms. Parker ever tried to hurt her.[182]

<u>Safety Plan</u>

A reasonably prudent CPI would have implemented a safety plan with L.P. cared for by V.D.C. and S.C. with supervised visitation between Ms. Parker and L.P. Safety plan is defined

[178] The Department, *CFOP 170-5 Child Protective Investigations,* 14-1 (Apr. 8, 2024).
[179] Hearing at 7:18:55-7:19:10; Tucker T-VII 1922: 16-21.
[180] Hearing at 7:24:15-7:24:55.
[181] *Id.* at 7:36:00-7:36:11.
[182] Chronological Notes at 4 (With respect to the face-to-face with L.P, indicating "no disclosures of harm or being scared.").

as "a plan created to control present or impending danger using the least intrusive means appropriate to protect a child when a parent, caregiver, or legal custodian is unavailable, unwilling, or unable to do so."[183]

A safety plan is required if "present or impending danger is identified."[184] Impending danger is defined as a "state of danger in which family behaviors, attitudes, motives, emotions or situations pose a threat that may not be currently active but can be anticipated to have severe effect on a child at any time."[185] Impending danger requires five criteria to be present: (1) imminence; (2) severity; (3) observability; (4) out-of-control of the family; and (5) vulnerability.[186] Parental consent is required to implement a safety plan.[187]

Ms. Parker's mental health issues, prior Baker Acts, previous suicidal notes, and suicide video are sufficient evidence that Ms. Parker was suicidal when she sent the video on June 25, 2015. The video was of Ms. Parker putting her affairs in order, suggesting further actions compounding her previous suicide threats, and establishing that a suicide attempt may have been imminent. Her erratic behavior and misleading statements did not dispel this evidence. The Department did not know Ms. Parker's whereabouts or when she would be home, which, it turns out, she was there when CPI Supervisor Tucker and CPI Lopez were conducting the home visit. If Ms. Parker had committed suicide with only L.P. present, L.P. may have experienced harm by witnessing it and she would have been at risk of harm for being unsupervised at such a young age – the reason for which the June 2015 report was received. For these reasons, the five criteria for impending danger are met in these specific circumstances.[188]

V.D.C.'s power of attorney for L.P. did not eliminate the need for a safety plan. "Power of attorney" is defined as "[a]n instrument granting someone authority to act as agent or

[183] Section 39.01(78), F.S.
[184] *See* s. 39.301(9)(a)6., F.S.
[185] Claimant's Exhibit 56. at 1.
[186] *Id.* at 1-2.
[187] Rule 65C-30.002(3)(a), F.A.C.; Section 39.401, F.S. (providing that a child may only be taken into custody in specified circumstances). Section 39.01(88), F.S. defines "taken into custody" as the status of a child immediately when temporary physical control over the child is attained by a person authorized by law, pending the child's release or placement.
[188] Section 39.301(9)(a)6., F.S., requires the CPI to implement a safety plan as soon as necessary to protect the child or take the child into custody if impending danger is identified.

attorney-in-fact for the grantor."[189] V.D.C.'s power of attorney for L.P. gave her legal authority to take certain actions or make decisions but did not provide her with custody of L.P. Without a clear understanding of the Department's expectations, V.D.C. could have, and indeed did, leave L.P. with Ms. Parker unsupervised. In other words, the power of attorney authorizing V.D.C. to make decisions, for instance, about L.P.'s medical issues did not mean, standing alone, that V.D.C. was not going to leave Ms. Parker alone with L.P. or that she would ensure Ms. Parker would not harm her. If the Department expected V.D.C. to undertake this role, the Department ought to have memorialized this understanding in a written safety plan with supervised visitation in these specific circumstances.

Accordingly, the Department failed to take steps that an ordinary prudent CPI would have taken in this instance. For these reasons, the undersigned finds that the Department breached the foregoing duties when conducting its investigation of L.P.'s potential inadequate supervision.

Proximate Cause

In order to prove negligence, the claimant must show that the breach of duty caused the specific injury or damage to the plaintiff.[190] Proximate cause is generally concerned with "whether and to what extent the defendant's conduct foreseeably and substantially caused the specific injury that actually occurred."[191] To prove proximate cause, the plaintiff generally must submit evidence that "there is a natural, direct, and continuous sequence between the [Department's] negligence and [the children's] injuries such that it can reasonably be said that but for the [Department's] negligence, the abuse [or neglect] to [L.P.] would not have occurred."[192]

In the proximate cause context, "foreseeability is concerned with the specific, narrow factual details of the case, not with the broader zone of risk the defendant created."[193] Harm is proximate "if prudent human foresight would lead one to

[189] Garner, B., *Definition of Power of Attorney*, Black's Law Dictionary (12th ed. 2024), available at POWER OF ATTORNEY | Secondary Sources | FE | Westlaw Edge (last visited Feb. 27, 2025).
[190] *Stahl v. Metro Dade Cnty.*, 438 So. 2d 14 (Fla. 3rd DCA 1983).
[191] *Amora*, 944 So. 2d at 435 (quoting *Goldberg v. Fla. Power & Light Co.,* 899 So.2d 1105, 116 (Fla. 2005) (quoting *McCain v. Fla. Power Corp.*, 593 So. 2d 500, 502 (Fla. 1992).
[192] *Id.* at 436.
[193] *McCain*, 593 So. 2d at 504.

expect that similar harm is likely to be substantially caused by the specific act or omission in question. In other words, human experience teaches that the same harm can be expected to recur if the same act or omission is repeated in a similar context."[194] The Florida Supreme Court held "…it is immaterial that the defendant could not foresee the **precise** manner in which the injury occurred or its **exact** extent[195]…an injury caused by a freakish and improbable chain of events would not be 'proximate' precisely because it is unquestionably unforeseeable, even where the injury may have arisen from a zone of risk."[196] (emphasis added). The Florida Supreme Court held:

> "On the issue of the fact of causation, as on other issues essential to his cause of action for negligence, the plaintiff, in general, has the burden of proof. He must introduce evidence which affords a reasonable basis for the conclusion that it is more likely than not that the conduct of the defendant was a substantial factor in bringing about the result. A mere possibility of such causation is not enough; and when the matter remains one of pure speculation or conjecture, or the probabilities are at best evenly balanced, it becomes the duty of the court to direct a verdict for the defendant."[197]

Florida Standard Jury Instruction 401.12 on legal cause (causation), which is the standard applicable to claimant's negligence claim provides in *Part A* of the Instruction:

> Negligence is a legal cause of injury if it directly and *in natural and continuous sequence produces or contributes substantially to producing such injury so that it can reasonably be said that, but for the negligence, the injury would not have occurred.* (Emphasis added).

Importantly*, Part B* of the instruction reads:

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[194] *Id*. (citing *Cone v. Inter County Tel. & Tel. Co.*, 40 So.2d 148, 149 (Fla. 1949)).
[195] *Id.* (citing *Restatement (Second) of Torts* s. 435 (1965)).
[196] *McCain*, 593 So.2d, at 504
[197] *Gooding v. Univ. Hosp. Supply*, 445 So.2d 1015, 1018 (Fla. 2013).

> In order to be regarded as a legal cause of an injury or damage, negligence need not be the only cause. Negligence may be a legal cause of injury or damages even though it operates in combination *with the act of another*, (such as A.P.) some natural cause, or some other cause if the negligence contributes substantially to producing such loss, injury, or damage. (Emphasis added).

In *Amora*, the Fourth District Court of Appeal held that "Although not specifically addressed in *Yamuni*, implicit in the supreme court's opinion affirming the verdict is that [the Department's] negligent failure to place the infant in protective supervision was the proximate cause of his injuries."[198]

The Department's failure to implement the safety plan with supervised visitation left L.P. at a foreseeable risk of harm. Like *Amora*, but for the Department's failure to implement a safety plan with supervised visits, Ms. Parker would not have attempted to murder L.P. Based on the totality of the circumstances set out above, the Department's breaches are the proximate cause of L.P.'s injuries. This finding is supported by the jury verdict in the underlying civil case.

For these reasons, the undersigned finds that there is sufficient evidence to hold that the Department's breach of duty was the proximate cause of L.P.'s injuries.

Damages

Florida law allows recovery for both economic (e.g. medical expenses) and non-economic (e.g. pain and suffering) damages.[199] Future economic damages may be awarded "when such damages are established with reasonable certainty."[200] "In tort cases damages are to be measured by the jury's discretion."[201] However, Florida courts have considered whether awards are excessive.[202]

The claimant presented evidence of economic damages and non-economic damages. The damages explained above in

[198] *Amora*, 944 So. 2d at 437.
[199] *Florida Patient's Compensation Fund v. Scherer*, 558 So. 2d 411 (Fla. 1990).
[200] *Auto-Owners Ins. Co. v. Tompkins*, 651 So. 2d 89, 91 (Fla. 1995).
[201] *Bould v. Touchette*, 349 So. 2d 1181, 1184 (Fla. 1977).
[202] *ACandS, Inc. v. Redd*, 703 So.2d 492, 495 (Fla. 3rd DCA 1997) (finding a jury award for $7.2 million for five and a half years of loss of consortium to be excessive).

the factual findings detail the jury verdict in the underlying civil case for which the amount of damages is sought, and which is supported by the expert reports in this claim bill. The undersigned did not have the benefit of hearing evidence from experts from both parties but relied upon the totality of the evidence to make the findings set out below.

Economic damages (present value) based on the economic damages report are summarized as follows:[203]

Past medical expenses:	$30,248.33
Lifetime earning capacity:	$1,170,184 to $1,916,929
Potential offset for earning capacity:	($300,987) to ($490,112)
Future Medical Expenses:	$7,932,170 to $14,002,766
Subtotal	$8,831,615.33 to 15,459,831.33
Total economic damages:	$8,304,351.33 to $14,651,891.33

Future Medical Costs

There is little to no evidence to support awarding the high-end ($14,002,766) versus the low-end ($7,932,170) future medical costs. The difference between the two totals is a significant amount totaling $6,070,596, most of which is attributable to the live in attendant residential option discussed below. The economic damages report suggests the remaining differences are based on, for instance, a range of costs, number of hours, or number of sessions per service. The range of frequency and costs were presented but choosing the higher range, rather than the lower range, was not substantiated. The burden of proof is on the claimant and the claimant has presented insufficient evidence to support the high-end costs.

Residential Option

Dr. Shahnasarian's recommendation of a live-in attendant beginning at age 18 to 21 for life is supported by his competent testimony. During the claim bill hearing issues were raised about whether the following may impact the life care plan and, in particular, the live-in attendant recommendation, such as (a) Dr. Shahnasarian's last interview or updates he has received about L.P. was in August and September 2021, respectively, over three (3) years ago, (b) L.P. has made progress since he interviewed her, such as forming social bonds with friends, and (c) L.P. has not been engaging in all of the recommended services in the life care plan that are supposed to serve as interventions

[203] Economic Damages Report at 2-9.

to improve her prospects of requiring such an intensive intervention as a live-in attendant. However, Dr. Shahnasarian addressed these issues and confirmed that his life care plan conclusions have not changed.

In light of the issues raised, the undersigned considered the other residential options B and C set out in the life care plan. These other options recommend less frequent attendant services, but the economists did not include a present value or calculate an average annual base cost for these possible options.[204] Although the life care plan sets out a duration, frequency and estimated cost for Option C so a cost for this intervention could be estimated, given Dr. Shahnasarian's testimony that Option C is unlikely, there is insufficient evidence to award damages under options B or C as presented for consideration.

Offsets and Services Not Received for Other Future Medical Recommended Services

The life care plan does not account for L.P.'s current Medicaid coverage, future insurance coverages, scholarships that may be available to assist with the private school tuition and the potential and actual cessation of services as indicated at the claim bill hearing where it was discovered that her only services currently are the weekly sessions with Dr. Cortman, psychiatric services, private school tuition, and medications that are likely covered by Medicaid. Further, V.D.C. and S.C. receive an adoption subsidy from the Department[205] and could apply for an enhanced subsidy based on L.P.'s special needs.[206] The claim bill also fails to take into account existing medical liens by Simply Health and Optum totaling $30,248.33 which will need to be satisfied should the bill pass.

Based on this, the undersigned recommends reducing the low-end economic damages sought by the following adjustments:

Family counseling:	($12,873)
Tutoring Year 1 to Grade 8:	($44,899)
Life skills (Year 1 to 3) cost of $15,600 per year:	($46,800)
Prescription drugs:	($288,777)

[204] *Id.*
[205] Hearing at 4:53:44-4:53:50.
[206] *Id.* at 4:53:55-4:54:15.

Totals:	($393,349)

Based on the foregoing, the recommended economic damages are summarized as follows:

Economic damages (present value) based on the economic damages report are summarized as follows:[207]

Past medical expenses (medical liens):	$30,248.33
Lifetime earning capacity:[208]	$1,500,000
Future Medical Expenses:	$7,538,821
Total economic damages:	$9,069,069.33

Non-economic Damages

The jury in the underlying civil claim awarded $12,466,985.47 in non-economic damages. The Second District Court of Appeal affirmed *per curiam* the final judgment in the underlying civil claim. However, the amount of non-economic damages awarded by the jury of $12,466,985.47 exceed the amount of economic damages supported by the record and recommended by the undersigned of $9,069,069.33. Precedence for claim bills regarding child welfare is limited and the undersigned did not identify any that are sufficiently analogous to the nature of this claim to be able to recommend a comparable amount of non-economic damages. The Legislature may wish to determine, as a matter of grace, an amount of non-economic damages, if any, that should be awarded in this claim bill.

COMPARATIVE FAULT:

Although the Department denies being negligent in its June 2015 report investigation, the Department submits that should SB 12 be reported favorably that V.D.C. is liable for a percentage of fault under the doctrine of comparative fault.

Claimant's Position

The Claimant submits that under the *Knight*[209] case V.D.C. had no duty to protect L.P. and therefore she is not comparatively negligent. The *Knight* case sets out the general rule that "there is no duty to control the conduct of a third

[207] Economic Damages Report at 2-9.
[208] The lifetime earning capacity is based on the jury verdict which the undersigned has determined to be reasonable.
[209] *Knight v. Merhige*, 133 So. 3d 1140 (2014).

person to prevent [that person] from causing physical harm to another."[210] However, a legal duty may be imposed when:

- There is a special relationship between the plaintiff and the defendant,[211]
- The defendant controls the premises, instrumentality or person causing the injury,[212] or
- The defendant's "affirmative acts or omissions create a foreseeable high risk of harm."[213]

In the *Knight* case parents failed to prevent their adult child from killing other family members at a Thanksgiving dinner. The court declined to impose a duty on a parent for their adult child's criminal actions. The Department stipulates that V.D.C. did not have a legal duty to speak with the Department. The undersigned finds that the facts of this claim bill are analogous to the *Knight* case to the extent that none of the three tests for imposing a legal duty in the *Knight* case apply in this claim bill.

The Department's Position

The Department submits that V.D.C. is liable under comparable fault based on the Restatement (Second) of Torts ss. 324A and 311 (1965). The Claimant submits these provisions do not apply; the *Knight* case is controlling law that establishes a "lack of duty and the inapplicability of the undertaker doctrine." Although the Legislature is not bound by the findings of the courts in this matter, it should be noted the claimant represented that the trial court granted the claimant's Motion in Liminie "…precluding comparative negligence arguments against V.D.C."[214] and, although the Department represented that the issue was argued on appeal,[215] the Second District Court of Appeal affirmed the judgment of the civil case *per curiam*.[216]

The Department submits, however that, even if V.D.C. has no duty to provide information to the investigators, V.D.C. had an "undertaker duty"; once she decided to answer questions for

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[210] *Id.* at 1145 (citing *Carney v. Gambel*, 751 So. 2d 653, 654 (Fla. 4th DCA 1999; *see also Boynton v. Burglass*, 590 So. 2d 446, 448 (Fla. 3d DCA 1991)).
[211] *Id.* at 1144.
[212] *Id.*
[213] *Koenig v. London*, 968 N.W. 2d 646, 656 (2021).
[214] Email from Damian Mallard, Attorney at Mallard Perez for the claimant, to Jacqueline Moody, Florida Senate Special Master, *RE: SB 12 – LXC (LP) v. DCF*, (Feb. 15, 2025) (on file with Senate Special Master).
[215] Email from Cheryl Westmoreland, Attorney for the Department, to Jacqueline Moody, Florida Senate Special Master, *RE: SB 12 – LXC (LP) v. DCF*, (Feb. 17, 20215) (on file with Senate Special Master).
[216] Limited documents were provided to support these assertions.

the Department she was required to do that voluntary act in a non-negligent manner.

> "Whenever one undertakes to provide a service to others, whether one does so gratuitously or by contract, the individual who undertakes to provide the service—i.e., the 'undertaker'—thereby assumes a duty to act carefully and not to put others at an undue risk of harm."[217]

The undertaker's doctrine, as set out in The Restatement (Second) of Torts s. 324A ("Section 324A") states:

> "One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking, if:
>
> (a) His failure to exercise reasonable care increases the risk of such harm, or
>
> (b) He has undertaken to perform a duty owed by the other to the third person, or
>
> (c) The harm is suffered because of reliance of the other or the third person upon the undertaking.

The Restatement (Second) of Torts is not binding. No Florida cases have been identified that directly apply section 324A to situations where a third party provides information to child protective services. There are limited cases in other states that have considered the doctrine – but found no duty owed - involving child welfare[218] and at least one Florida court applied the doctrine involving the protection of third parties by another.[219]

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[217] *Clay Elec. Co-op., Inc. v. Johnson*, 873 So.2d 1182, 1186 (Fla. 2003)
[218] *See Roe ex rel. Roe v. Department of Social & Rehabilitation Services*, 278 Kan. 584 (2004) (holding that the Department of Social & Rehabilitative Services did not owe a duty under the Restatement (Second) of Torts s. 324A given the facts of the case).
[219] *See Wallace v. Dean*, 3 So. 3d 1035 (Fla. 2009) (holding the Restatement (Second) of Torts s. 324A applied where a law enforcement officer who responded to a 911 call and undertook a safety check on an individual assumed a duty to exercise reasonable care).

However, in such instances, an entity provided the services, not an individual. Section 324A has been applied to other types of cases where individuals have rendered services.[220] But no Florida case has been identified directly applying Section 324A to situations where an individual, in a non-official capacity, provides information that is deemed a service.

The Department simply argues that V.D.C. undertook a duty to act carefully when she voluntarily went out to meet and provided information to the investigators. With respect to applying section 324A, this submission falls short of the requirement of (b) [V.D.C.] undertook to perform a duty owed by the other person [Ms. Parker or the Department] to a third person [L.P.]. Providing information was not a duty of the Department or Ms. Parker. Applying section 24 to the evidence in this claim bill:

(a) V.D.C.'s failure to exercise reasonable care increased the risk of harm to L.P. by leaving Ms. Parker alone with L.P.
(b) V.D.C. may have undertaken responsibility that another (the Department or Ms. Parker) originally had toward L.P. by presenting the power of attorney and suggesting that she was caring for her, but she did not give any undertaking for how long she planned to care for her, that she would keep custody of her, or that she would protect L.P. from Ms. Parker.
(c) The Department did rely on V.D.C.'s representation that she had power of attorney and was caring for L.P.

Based on the above analysis, Section 324A would fall short and not apply to the facts of this claim bill.

Additionally, Restatement (Second) of Torts s. 311 (1965) ("section 311) states: "one who negligently gives false information to another is subject to liability for physical harm caused by action taken by the other in reasonable reliance upon such information, where such harm results…to such third persons as the actor should expect to be put in peril by the action taken."

[220] *See Union Park Memorial Chapel v. Hutt*, 670 So. 2d 64 (Fla. 1996) (holding the Restatement (Second) of Tort s. 324A applied where a funeral home that voluntarily organized and led a funeral procession owed a duty of reasonable care to the participants, noting that the funeral home's undertaking created a foreseeable zone of risk for those involved.)

No Florida state case has been identified directly applying section 311, but a few federal cases in Florida have considered the provision.[221] Other states' cases have considered section 311 in abuse cases when organizations (such as a private foster-placement organization or school board) and their employees have been alleged to provide false information.[222] No analogous cases were identified where an individual made false statements to child protection services that were relied upon and resulted in harm; section 311 comments provide that "the rule is not, however, limited to information given in a business or professional capacity, or to those engaged in a business or profession."[223]

Applying the provision to the facts in this case:

- Undertaking a duty: V.D.C. undertook to provide information to the Department, recognizing it was necessary for L.P.'s protection.
- Negligent misrepresentation: V.D.C. provided false information without exercising reasonable care. On June 25, 2015, V.D.C.:
    - Informed CPI Supervisor and CPI Supervisor Tucker that Ms. Parker was not there when in fact Ms. Parker was present and misidentifying herself as Valencia Dubois. Had Ms. Carey in fact informed them that Ms. Parker was inside the house, as she testified to during the claim bill hearing, the undersigned is confident that the Department would have taken additional steps to confront Ms. Parker about her lies and the allegations.
    - Misled the CPI Supervisor Tucker and CPI Lopez to believe that Ms. Parker gave her power of attorney because Ms. Parker reportedly did hair in Orlando. However, V.D.C.'s own statements to CPI Supervisor Tucker on June 26, 2015, the day after

[221] *See In re: Zantac (Ranitidine) Products Liability Litigation*, 546 F.Supp. 3d 1192, 1199 (S.D. Fla. 2021) (acknowledging that the defendant, pharmaceutical manufacturer, could be held liable for claims that are on based on negligent representation articulated in Section 311); *Belik v. Carlson Travel Group, Inc.*, 26 F.Supp. 3d 1267, 1273 (denying the defendants' motion to dismiss on forum non conveniens a Section 311 claim, amongst others, brought by a cruise ship passenger who was injured at a restaurant in a cruise ship terminal in Mexico); *Klein v. Receivable Management Group, Inc.*, 595 F.Supp.3d 1183, 1191 (M.D. Fla. 2022) (holding a consumer's Section 311 claim against a debt collector alleged insufficient damages).
[222] *See M.B. v. Schuylkill County*, 375 F.Supp. 3d 574, 602-603 (E.D. Penn. 2019) (holding that Pennsylvania adopted Section 311 and a private foster-placement organization, caseworker, and employees could be held liable under Section 311 for failing to disclose a foster child's sexual history that resulted in another child in the home being sexually abused).
[223] Section 311.

the home visit, made clear that the purpose of the power of attorney was to prevent the Department from taking L.P. if an abuse report was made against Ms. Parker. The information Ms. Parker and V.D.C. told CPI Supervisor Tucker and CPI Lopez on June 25, 2015, did just that – kept L.P. in Ms. Parker's custody. On June 26, 2015, when CPI Supervisor Tucker interviewed V.D.C. after the stabbing incident, the following conversation took place:

"CPI Supervisor Tucker: So how – how did you end up with power of attorney?
Ms. Carry (sic): I can't answer about that because I don't remember right off hand.
CPI Supervisor Tucker: But it was back in 2009?
Ms. Carry (sic): Uh-huh
CPI Supervisor Tucker: Okay.
Ms. Carry (sic): I think what it was when someone had called DCF on her, and I said before I let anybody else take my baby from me,
CPI Supervisor Tucker: Okay.
Ms. Carry (sic): -- sign her over to me.
CPI Supervisor Tucker: Okay. Okay.
Ms. Carry (sic): Yeah. That's all I can remember to tell you.
CPI Supervisor Tucker: Okay. So who –
Ms. Carry (sic): People used to call (indiscernible) every week.
CPI Supervisor Tucker: And why was that?
Ms. Carry (sic): I have no idea.
CPI Supervisor Tucker: Okay.
Ms. Carry (sic): Okay. And so I told her to make sure she signs her over to me because I will take care of her."[224]

- Reasonable reliance: The Department reasonably relied[225] upon information provided by V.D.C. when deciding to leave L.P. in Ms. Parker's care based on the information corroborated by V.D.C. at the time.

[224] Video Interview of V.D.C. 13:45:27-13:47:47 (June 26, 2015).
[225] Reliance is measured by an objective standard. *In re Marjory Stoneman Douglas High School Shooting FTCA Litigation*, 482 F.Supp. 3d 1273, 1297 (S.D. Fla. 2020).

- Foreseeable harm: It was foreseeable that such information could lead to L.P.'s physical harm. If the Department relied on V.D.C.'s false statements and decided not to take protective measures, it is foreseeable that L.P. would be at risk of harm if left unsupervised with Ms. Parker.[226]

Despite the lack of precedence, should the Legislature decide to apply section 311, there are sufficient facts to support a finding that V.D.C. undertook a duty to exercise reasonable care and is liable under the doctrine of comparative fault for providing false information to the Department in these circumstances.

ATTORNEY FEES:

In compliance with section 768.28(8), of the Florida Statutes, Claimant's attorneys acknowledged that attorney fees, lobbying fees, and other similar expenses relating to this claim may not exceed 25 percent of any amount awarded by the Legislature as is reflected in the language of the bill.

RECOMMENDATIONS:

Recommended Amendments
Lines 3-8 of the claim bill should be amended to remove the appropriation to Sidney and Valeria Carey and reflect the award going to L.P. directly paid to the Special Needs Trust created for her benefit. Lines 12 and 21 of the claim bill should be amended to reflect the date of the incident was June 25, 2015.

Recommendation on the Merits
The greater weight of the evidence in this matter demonstrates that the negligence of the Department is the legal proximate cause of the injuries and damage suffered by L.P.

Based on the evidence supported by the record, the undersigned recommends economic damages in the amount of $9,069,069.33. The Legislature may wish to exercise its discretion by awarding non-economic damages as a matter of grace.

[226] *Garcia v. Superior Court*, 50 Cal. 3d 728, 734 (Cal. 1990) (apply a standard of reasonable care suggesting an objective standard should apply).

Accordingly, the undersigned recommends that SB 12 be reported FAVORABLY, with recommended amendments, the funds allocated for the benefit of L.P. being paid into a Special Needs trust established for L.P., and any reduction in amount deemed appropriate by the Legislature.

Respectfully submitted,

Jacqueline M. Moody
Senate Special Master

cc: Secretary of the Senate

CS by Judiciary

The committee substitute clarifies that the funds awarded by the claim bill are for the exclusive benefit of L.P. Additionally, the committee substitute no longer includes amounts in the whereas clauses describing the cost of the claimant's past and future medical care and lost earning capacity.

By the Committee on Judiciary; and Senator Gruters

590-03189-25 202512c1

A bill to be entitled

An act for the relief of L.P., a minor, by the Department of Children and Families; providing an appropriation to a special needs trust, to compensate L.P. for injuries and damages sustained due to the negligence of employees and caseworkers of the department; providing a limitation on compensation and the payment of fees and costs; providing an effective date.

WHEREAS, on June 25, 2015, a family member of the then-6-year-old L.P. called the Sarasota Police Department to request a wellness check of the mother of L.P. due to a suicide video the mother sent to relatives, along with other bizarre behaviors that called her mental fitness into question, and

WHEREAS, in response to this call, the Sarasota Police Department complied with its statutory duty to report known or possible child abuse by notifying the Department of Children and Families (DCF), which, through its employees and caseworkers, responded to the home late on June 25, 2015, but failed to identify the mother of L.P., much less identify several forewarnings as to the mother's mental health status, and

WHEREAS, because of the inadequate wellness check by DCF employees, including failure to implement a readily available safety plan, L.P. was left in the custody of her mother, rather than her grandmother, who is now her adopted mother and who lived just a few houses away, and

WHEREAS, because of the negligence of the DCF caseworkers to recognize the danger to L.P., she was left in her mother's

590-03189-25 202512c1

custody, and

WHEREAS, the mother of L.P. attempted to murder L.P. within hours after DCF's negligent decision, resulting in L.P. being stabbed no fewer than 14 times, including an attempted disembowelment, which required emergency surgery to save her life and multiple follow-up surgeries and treatments, and

WHEREAS, as a further consequence of the negligence of DCF through its employees, L.P. will incur a lifetime of significant pain, suffering, disability, disfigurement, mental anguish, inconvenience, loss of capacity for the enjoyment of life, medical costs, future surgeries, and psychological costs over a potential duration of more than 65 years, and

WHEREAS, following a 2-week trial from February 28 through March 11, 2022, the jury found DCF negligent and awarded L.P. damages resulting in a final judgment in the amount of $28 million, and

WHEREAS, an appeal to the Second District Court of Appeal affirmed the factual findings and the judgment of the jury and trial court in the case, and

WHEREAS, in the 9 years since her mother attempted to murder her, L.P. has incurred the costs of multiple lifesaving surgeries, psychological counseling, and related expenses which remain unpaid or will be incurred, along with a loss of earning capacity, and

WHEREAS, the costs incurred in the prosecution of the claims on behalf of L.P. exceeded $208,000, with over $8,000 remaining to be paid, and

WHEREAS, in accordance with the statutory cap of liability set forth in s. 768.28, Florida Statutes, DCF has paid $200,000

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

toward the total amount of this claim, NOW, THEREFORE,

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

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. The sum of $28 million is appropriated from the General Revenue Fund to the Department of Children and Families for the relief of L.P. for injuries and damages sustained.

Section 3. The Chief Financial Officer is directed to draw a warrant in the sum of $28 million payable to a special needs trust created for the exclusive use and benefit of L.P. for injuries and damages sustained.

Section 4. The amount paid by the Department of Children and Families pursuant to s. 768.28, Florida Statutes, and the amount awarded under this act are intended to provide the sole compensation for all present and future claims arising out of the factual situation described in this act which resulted in injuries and damages to L.P. The total amount paid for attorney fees, lobbying fees, and other similar expenses relating to this claim may not exceed 25 percent of the total amount awarded under this act.

Section 5. This act shall take effect upon becoming 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 Appropriations Committee on Health and Human Services

BILL:	CS/SB 526
INTRODUCER:	Health Policy Committee and Senator Harrell
SUBJECT:	Nursing Education Programs
DATE:	April 14, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.	Gerbrandt	McKnight	AHS	**Pre-meeting**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 526 amends s. 464.019, F.S., related to the approval of nursing education programs, to:

- Revise program application requirements;
- Authorize the Board of Nursing (BON) to deny certain program applications;
- Revise annual reporting requirements and authorize the BON to terminate programs that do not meet reporting requirements;
- Revise the criteria by which the BON may terminate a program for not meeting certain graduate passage rates;
- Authorize the Department of Health to conduct onsite inspections to determine compliance;
- Revise the BON rule-making authority; and
- Repeal the BON's rule-making authority to grant an extension of the accreditation deadline.

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

The bill takes effect 1, 2025.

II. Present Situation:

Florida Postsecondary Nursing Education Programs

As of January 9, 2025, the Florida Board of Nursing (BON) has approved 314 Registered Nurse (RN) programs, five Professional Diploma programs, and 194 Practical Nursing (LPN) programs for pre-licensure education.[1] Pre-licensure nursing programs include pre-licensure programs offered by Florida's state universities, colleges, public school districts, private institutions licensed by the Florida Commission for Independent Education (CIE), private institutions that are members of the Independent Colleges and Universities of Florida (ICUF), and religious institutions authorized by law to offer nursing programs.[2]

Post-licensure nursing programs advance the training of licensed RNs and include Registered Nurse to Bachelor of Science in Nursing (RN to BSN), Master of Science in Nursing (MSN), Doctor of Nursing Practice (DNP), Doctor of Philosophy (Ph.D.) programs, and nursing certificates. Upon completion of some master's and doctorate programs, RNs transition to an advanced practice registered nurse (APRN) license. These roles include nurse practitioner (NP), certified nurse midwife (CNM), clinical nurse specialist (CNS), psychiatric mental health nurse practitioner, and certified registered nurse anesthetist (CRNA).[3]

Pre-licensure Nursing Education Programs

Educational institutions that wish to conduct a program in Florida for the pre-licensure education of RNs or LPNs must meet specific requirements to be approved by the BON.[4] The program application must include the legal name of the educational institution, the legal name of the nursing education program, and, if such institution is accredited, the name of the accrediting agency. The application must also document:[5]

- For an RN education program, the program director and that at least 50 percent of the program's faculty members must be RNs who have a master's degree or higher in nursing or a bachelor's degree in nursing and a master's or higher degree in a field related to nursing;
- For an LPN education program, the program director and at least 50 percent of the program's faculty members must be RNs who have a bachelor's degree or higher in nursing;
- The program's nursing major curriculum consists of at least:
  - Fifty percent clinical training in the U.S., the District of Columbia (D.C.), or a possession or territory of the U.S. for an LPN, ARN, or a diploma RN;
  - Forty percent of clinical training in a U.S. state, D.C., or a possession or territory of the U.S. for a Bachelor of Science degree RN education program, and no more than 50 percent of the program's clinical training may consist of clinical simulation;

[1] Department of Health, *Senate Bill 526 Legislative Analysis* (Feb. 28, 2025) (on file with the Senate Committee on Health Policy).
[2] Florida Center for Nursing (2025), *The State of Nursing Education in Florida - 2025*, Tampa, Fla., available at https://issuu.com/flcenterfornursing/docs/newthestateofnursingeducationinflorida (last visited Feb. 28, 2025).
[3] *Id.*
[4] Section. 464.019, F.S. and Florida Board of Nursing, *Education and Training Programs*, available at https://floridasnursing.gov/education-and-training-programs/ (last visited Feb. 28, 2025).
[5] Section 464.019(1), F.S.

- The RN and LPN educational degree requirements may be documented by an official transcript or by a written statement from the educational institution verifying that the institution conferred the degree;
- The program must have signed agreements with each agency, facility, and organization included in the curriculum plan as clinical training sites and community-based clinical experience sites;
- The program must have written policies for faculty which include provisions for direct or indirect supervision by faculty or clinical preceptors for students in clinical training consistent with the following standards;
    - The number of program faculty members must equal at least one faculty member directly supervising every 12 students unless the written agreement between the program and the agency, facility, or organization providing clinical training sites allows more students, not to exceed 18, to be directly supervised by one program faculty member;
    - For a hospital setting, indirect supervision may occur only if there is direct supervision by an assigned clinical preceptor and a supervising program faculty member is available by telephone, and such arrangement is approved by the clinical facility;
    - For community-based clinical experiences that involve student participation in invasive or complex nursing activities, students must be directly supervised by a program faculty member or clinical preceptor and such arrangement must be approved by the community-based clinical facility;
    - For community-based clinical experiences not involving student participation in invasive or complex nursing activities, indirect supervision may occur only when a supervising program faculty member is available to the student by telephone; and
    - A program's clinical training policies must require that a clinical preceptor who is supervising students in an RN education program be an RN or, if supervising students in an LPN education program, be an RN or LPN;
- The RN or LPN nursing curriculum plan must document clinical experience and theoretical instruction in medical, surgical, obstetric, pediatric, and geriatric nursing. An RN curriculum plan must also document clinical experience and theoretical instruction in psychiatric nursing. Each curriculum plan must document clinical training experience in appropriate settings that include, but are not limited to, acute care, long-term care, and community settings;
- An RN or LPN education program must provide theoretical instruction and clinical application in the following:
    - Personal, family, and community health concepts;
    - Nutrition;
    - Human growth and development throughout the lifespan;
    - Body structure and function;
    - Interpersonal relationship skills;
    - Mental health concepts;
    - Pharmacology and administration of medications; and
    - Legal aspects of practice; and
- An RN nursing education program must also provide theoretical instruction and clinical experience in:
    - Interpersonal relationships and leadership skills;
    - Professional role and function; and
    - Health teaching and counseling skills.

Program Approval Process

Upon receipt of a program application and the required fee, the Department of Health (DOH) must examine the application to determine if it is complete. If the application is not complete, the DOH must notify the educational institution in writing of any errors or omissions within 30 days after the DOH's receipt of the application. A program application is deemed complete upon the DOH's receipt of:

- The initial application, if the DOH does not notify the educational institution of any errors or omissions within the initial 30-day period after receipt; or
- Upon receipt of a revised application that corrects each error and omission that the DOH has notified the applicant of within the initial 30-day period after receipt of the application.[6]

Once a complete application is received, the BON may conduct an onsite evaluation if necessary to document the applicant's curriculum and staffing. Within 90 days after the DOH's receipt of the complete program application, the BON must:

- Approve the application; or
- Provide the educational institution with a Notice of Intent to Deny if information or documents are missing.[7]

The notice must specify in writing the reasons for the BON's denial of the application, and the BON may not deny an application because an educational institution failed to correct an error or omission that the DOH failed to notify the institution of within the 30-day notice period. The educational institution may request a hearing on the Notice of Intent to Deny the application pursuant to ch. 120, F.S. A program application is deemed approved if the BON does not act within the 90-day review period. Upon the BON's approval of a program application, the program becomes an "approved" program.[8]

Approved Nursing Pre-licensure Education Programs Annual Report

Each approved pre-licensure education program must submit to the BON an annual report by November 1, which must include:

- An affidavit certifying continued compliance with s. 465.019(1), F.S;
- A summary description of the program's compliance with s. 465.019(1), F.S; and
- Documentation for the previous academic year that describes:
  - The number of student applications received, qualified applicants, applicants accepted, accepted applicants who enroll in the program, students enrolled in the program, and program graduates;
  - The program's retention rates for students tracked from program entry to graduation; and
  - The program's accreditation status, including identification of the accrediting agency.[9]

[6] Sections 464.019(2) and 464.003(4), F.S.
[7] *Id*.
[8] *Id*.
[9] Section 464.019(3), F.S.

If an approved program fails to submit the required annual report, the BON must notify the program director and president or chief executive officer of the institution in writing within 15 days after the due date. The program director must appear before the BON to explain the delay. If the program director fails to appear, or if the program does not submit the annual report within six months after the due date, the BON must terminate the program.[10]

Approved Nursing Pre-licensure Education Programs Accountability

Graduate Passage Rates

An approved nursing pre-licensure education program must achieve a graduate National Council of State Boards of Nursing Licensing Examination (NCLEX) passage rate of first-time test takers which is not more than ten percentage points lower than the average passage rate during the same calendar year for graduates of comparable degree programs who are U.S. educated, first-time test takers, as calculated by the contracted testing service of the National Council of State Boards of Nursing.[11]

For purposes of s. 464.019(5), F.S., an approved program is comparable to all degree programs of the same program type from among the following program types:[12]

- RN nursing education programs that terminate in a bachelor's degree;
- RN nursing education programs that terminate in an associate degree;
- RN nursing education programs that terminate in a diploma; and
- LPN nursing education programs.

If an approved program's graduate passage rates do not equal or exceed the required passage rates for two consecutive calendar years, the BON must place the program on probationary status and the program director must appear before the BON to present a remediation plan, which must include specific benchmarks to identify progress toward a graduate passage rate goal. The program must remain on probationary status until it achieves a graduate passage rate that equals or exceeds the required passage rate for any one calendar year.[13]

The BON must deny a program application for a new pre-licensure nursing education program submitted by an educational institution if the institution has an existing program that is already on probationary status. Upon the program's achievement of a graduate passage rate that equals or exceeds the required passage rate, the BON must remove the program's probationary status.

If the program, during the two calendar years following its placement on probation, does not achieve the required passage rate for any one calendar year, the BON may extend the program's probationary status for one additional year if certain criteria are met. If the program is not granted the one-year extension or fails to achieve the required passage rate by the end of the extension, the BON must terminate the program. If students from a program that is terminated transfer to an approved or accredited program under the direction of the Commission for Independent Education, the BON must recalculate the passage rates of the programs receiving

[10] Section 464.019(5). F.S.
[11] Section 464.019(5). F.S.
[12] *Id.*
[13] *Id.*

the transfer students and exclude the test scores of those students transferring more than 12 credits.[14]

An "accredited" nursing education program is a program for the pre-licensure education of RNs or LPNs that is conducted at a U.S. educational institution, whether in Florida, another state, or D.C., and that is accredited by a specialized nursing accrediting agency that is nationally recognized by the U.S. Secretary of Education to accredit nursing education programs.[15] Accredited programs do not have to meet requirements related to program application, approval, or submission of annual reports to the BON.[16]

All approved and accredited programs must meet accountability requirements related to the graduate passage rate on the NCLEX.

All approved nursing programs, except those specifically excluded,[17] must seek accreditation within five years of enrolling the program's first students.[18] An approved program that has been placed on probation must disclose its probationary status in writing to the program's students and applicants.[19] If an accredited program ceases to be accredited, the educational institution conducting the program must provide written notice to that effect to the BON, the program's students and applicants, and each entity providing clinical training sites or experiences. It may then apply to be an approved program.[20]

Board of Nursing Rulemaking Authority

The BON does not have rulemaking authority to administer s. 464.019, F.S., except:

- The BON must adopt rules that prescribe the format for submitting program applications and annual reports, and to administer the documentation of the accreditation of nursing education programs.[21]
- The board may adopt rules relating to the nursing curriculum, including rules relating to the uses and limitations of simulation technology, and rules relating to the criteria to qualify for an extension of time to meet the accreditation requirements.[22]

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[14] *Id.*
[15] Section 464.003(1), F.S. Eligible institutional and accrediting Agencies available to Florida Nursing Programs are: Accreditation Commission for Education in Nursing (ACEN), Inc., formerly, National League for Nursing Accrediting Commission; Commission on Collegiate Nursing Education (CCNE)); National League for Nursing Commission for Nursing Education Accreditation (NLN CNEA); National Nurse Practitioner Residency and Fellowship Training Consortium;. and Florida Board of Nursing, *See* U.S. Department of Education, Accreditation in the U.S., available at https://www.ed.gov/laws-and-policy/higher-education-laws-and-policy/college-accreditation/college-accreditation-united-states/college-accreditation-in-the-united-states--pg-4#National_Institutional#National_Institutional (last visited Feb. 28, 2025); and Florida Board of Nursing, *What is the difference between an "approved" and an "accredited" pre-licensure nursing education program in Florida?* available at https://floridasnursing.gov/help-center/what-is-the-difference-between-an-approved-and-an-accredited-pre-licensure-nursing-education-program-in-florida/ (last visited Feb. 28, 2025).
[16] Section 464.019(9), F.S.
[17] Excluded institutions are those exempt from licensure by the Commission of Independent Education under ss. 1005.06(1) and 464.019(11)(d), F.S.
[18] Section 464.019(11)(a)-(d), F.S.
[19] *Id.*
[20] Section 464.019(9)(b), F.S.
[21] Section 464.019(8), F.S.
[22] *Id.*

Under these rulemaking requirements and authority, the BON may not impose any condition or requirement on an educational institution submitting a program application, an approved program, or an accredited program, except as expressly provided in s. 464.019, F.S.[23]

III. Effect of Proposed Changes:

The bill amends s. 464.019, F.S., to add the following requirements to the application process for nursing education program approval:

- The legal name of the nursing education program director must be included;
- The nursing educational program's annual report to the Board of Nursing (BON) must be submitted by the program director;
- The nursing education program must have evaluation and standardized admission criteria that identify students who are likely to need additional educational support and a student academic support plan; and
- The nursing education program must have a comprehensive examination to prepare nursing students for the National Council of State Boards of Nursing Licensing Examination (NCLEX);
    - This type of comprehensive examination:
        - Must be termed an "exit examination" that all nursing education programs will administer;
        - May not be the sole exclusion to graduation if the student has otherwise completed all coursework required by the program; and
        - The program director must be responsible for ensuring that the program's average exit exam results are placed on the program's website and reported to the BON along with the annual report.

The nursing education program must submit to the BON established criteria for remediation that will be offered to students who do not successfully pass the exit examination. A program with NCLEX passage rates at least ten percentage points below the average passage rate for the most recent calendar year must offer remediation at no additional cost or refer the student to an approved remedial program and pay for that program for the student.

The bill requires the BON to deny an application from a nursing education program that has had adverse action taken against it by another regulatory jurisdiction in the U.S. The BON may also revoke the approval of an existing approved program that has had adverse action taken against it by another regulatory jurisdiction in the U.S.

The bill requires the program director to submit to the BON a written remediation plan with specific nationally-recognized benchmarks to identify progress toward a graduate passage rate goal, and to present that plan to the BON. If the program director fails to submit the required written remediation plan, or fails to appear before the BON to present the remediation plan no later than six months after the date of the program being placed on probation, the bill requires the BON to terminate the nursing education program and the program director is subject to

[23] *Id.*

professional discipline for failing to perform any statutory or legal obligation placed upon a licensee.

The bill authorizes agents or employees of the Department of Health (DOH) to conduct onsite evaluations or inspections at reasonable hours to ensure that approved programs or accredited programs are in full compliance with ch. 464, F.S., or to determine whether ch. 464, F.S., or s. 456.072, F.S., is being violated. The DOH may collect any evidence necessary or as required to ensure compliance with ch. 464, F.S. or for prosecution. A refusal by a nursing education program to allow an onsite evaluation or inspection is deemed a violation of a legal obligation imposed by the BON and the DOH.

The bill grants rulemaking authority to the BON to enforce and administer s. 464.019(5), F.S.; and repeals the BON rulemaking authority to establish the criteria for nursing education programs to qualify for an extension of time to meet the accreditation requirements under s. 464.019(11), F.S., and repeals s. 464.019(11)(f), F.S., which gives the BON authority to grant an extension of the accreditation deadline.

The bill takes effect July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

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

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 464.019 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on March 4, 2025:
The CS retains current law by providing that if a nursing program's graduate passage rates do not equal or exceed the required passage rates for two calendar years, then the Board of Nursing must place the program on probationary status. The underlying bill changed the threshold to one calendar year.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

. . . . . .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (5) is added to section 464.008, Florida Statutes, and subsection (1) of that section is republished, to read:

464.008 Licensure by examination.—

(1) Any person desiring to be licensed as a registered nurse or licensed practical nurse shall apply to the department


698194

to take the licensure examination. The department shall examine each applicant who:

(a) Has completed the application form and remitted a fee set by the board not to exceed $150 and has remitted an examination fee set by the board not to exceed $75 plus the actual per applicant cost to the department for purchase of the examination from the National Council of State Boards of Nursing or a similar national organization.

(b) Has provided sufficient information on or after October 1, 1989, which must be submitted by the department for a statewide criminal records correspondence check through the Department of Law Enforcement.

(c) Is in good mental and physical health, is a recipient of a high school diploma or the equivalent, and has completed the requirements for:

1. Graduation from an approved program;

2. Graduation from a prelicensure nursing education program that the board determines is equivalent to an approved program;

3. Graduation on or after July 1, 2009, from an accredited program; or

4. Graduation before July 1, 2009, from a prelicensure nursing education program whose graduates at that time were eligible for examination.

Courses successfully completed in a professional nursing education program that are at least equivalent to a practical nursing education program may be used to satisfy the education requirements for licensure as a licensed practical nurse.

(d) Has the ability to communicate in the English language,

which may be determined by an examination given by the department.

(5) Pursuant to s. 464.019(1)(k) establishing graduate nursing preceptorships, the department shall issue a provisional license to such graduates who also meet the criteria in paragraphs (1)(b), (c), and (d).

Section 2. Subsections (1) through (6) and (8) and paragraph (f) of subsection (11) of section 464.019, Florida Statutes, are amended to read:

464.019 Approval of nursing education programs.—

(1) PROGRAM APPLICATION.—An educational institution that wishes to conduct a program in this state for the prelicensure education of professional or practical nurses must submit to the department a program application and review fee of $1,000 for each prelicensure nursing education program to be offered at the institution's main campus, branch campus, or other instructional site. The program application must include the legal name of the educational institution, the legal name of the nursing education program, the legal name of the nursing education program director, and, if such institution is accredited, the name of the accrediting agency. The application must also document that:

(a)1. For a professional nursing education program, the program director and at least 50 percent of the program's faculty members are registered nurses who have a master's or higher degree in nursing or a bachelor's degree in nursing and a master's or higher degree in a field related to nursing.

2. For a practical nursing education program, the program director and at least 50 percent of the program's faculty members are registered nurses who have a bachelor's or higher

698194

degree in nursing.

The educational degree requirements of this paragraph must ~~may~~ be documented by an official transcript or by a written statement from the program director of the educational institution verifying that the institution conferred the degree. The program director shall certify the official transcript or written statement as true and accurate.

(b) The program's nursing major curriculum consists of at least:

1. Fifty percent clinical training in the United States, the District of Columbia, or a possession or territory of the United States for a practical nursing education program, an associate degree professional nursing education program, or a professional diploma nursing education program.

2. Forty percent clinical training in the United States, the District of Columbia, or a possession or territory of the United States for a bachelor's degree professional nursing education program.

(c) No more than 50 percent of the program's clinical training consists of clinical simulation.

(d) The program has signed agreements with each agency, facility, and organization included in the curriculum plan as clinical training sites and community-based clinical experience sites.

(e) The program has written policies for faculty which include provisions for direct or indirect supervision by program faculty or clinical preceptors for students in clinical training consistent with the following standards:

698194

1. The number of program faculty members equals at least one faculty member directly supervising every 12 students unless the written agreement between the program and the agency, facility, or organization providing clinical training sites allows more students, not to exceed 18 students, to be directly supervised by one program faculty member.

2. For a hospital setting, indirect supervision may occur only if there is direct supervision by an assigned clinical preceptor, a supervising program faculty member is available by telephone, and such arrangement is approved by the clinical facility.

3. For community-based clinical experiences that involve student participation in invasive or complex nursing activities, students must be directly supervised by a program faculty member or clinical preceptor and such arrangement must be approved by the community-based clinical facility.

4. For community-based clinical experiences not subject to subparagraph 3., indirect supervision may occur only when a supervising program faculty member is available to the student by telephone.

A program's policies established under this paragraph must require that a clinical preceptor who is supervising students in a professional nursing education program be a registered nurse or, if supervising students in a practical nursing education program, be a registered nurse or licensed practical nurse.

(f) The professional or practical nursing curriculum plan documents clinical experience and theoretical instruction in medical, surgical, obstetric, pediatric, and geriatric nursing.

698194

A professional nursing curriculum plan must ~~shall~~ also document clinical experience and theoretical instruction in psychiatric nursing. Each curriculum plan must document clinical training experience in appropriate settings that include, but are not limited to, acute care, long-term care, and community settings.

(g) The professional or practical nursing education program provides theoretical instruction and clinical application in personal, family, and community health concepts; nutrition; human growth and development throughout the life span; body structure and function; interpersonal relationship skills; mental health concepts; pharmacology and administration of medications; and legal aspects of practice. A professional nursing education program must also provide theoretical instruction and clinical application in interpersonal relationships and leadership skills; professional role and function; and health teaching and counseling skills.

(h) The professional or practical nursing education program has established evaluation and standardized admission criteria. The admission criteria must, at a minimum, identify those students who are likely to need additional educational support to be successful program graduates. The program must maintain documentation of the individualized student academic support plan for those students identified as in need of additional preparation and educational support.

(i) For each student, the professional or practical nursing education program administers an exit examination that is a national, standardized, and comprehensive predictor exam designed to help nursing students assess their readiness for the National Council of State Boards of Nursing Licensing

698194

Examination (NCLEX) by identifying areas needing further study and remediation. The exit examination may not be the sole exclusion to graduation if the student has otherwise successfully completed all coursework required by the program.

(j) The professional or practical nursing education program has submitted to the board the established criteria for remediation that will be offered to students who do not successfully pass the exit examination.

(k) Beginning August 1, 2026, a program with more than 10 percentage points lower than the average passage rate during the same calendar year for graduates of comparable degree programs who are United States-educated, first-time test takers on the NCLEX, as calculated by the contract testing service of the National Council of State Boards of Nursing, shall offer a graduate nursing preceptorship to its graduates. All programs are encouraged to offer a graduate nursing preceptorship to their graduates to provide opportunities for job shadowing, clinical training, nonclinical training, and patient care in a hospital setting. A graduate nursing preceptorship must last for 3 months, with the expectation that graduates will take the NCLEX at the conclusion of the preceptorship. Graduate registered nurses and graduate licensed practical nurses must be supervised by clinical preceptors. The department shall issue temporary provisional registered nurse licenses to a graduate of a registered nursing program. The department shall issue temporary provisional licensed practical nurse licenses to a graduate of a licensed practical nursing program. If the examination, professional or practical nursing education program must offer remediation to the graduate for free. By January 1,


698194

2026, the Florida Center for Nursing shall establish standards for graduate nursing preceptorships, including supervision requirements. The board shall incorporate the standards into rule.

(2) PROGRAM APPROVAL.—

(a) Upon receipt of a program application and review fee, the department shall examine the application to determine if it is complete. If the application is not complete, the department must ~~shall~~ notify the educational institution in writing of any errors or omissions within 30 days after the department's receipt of the application. A program application is deemed complete upon the department's receipt of:

1. The initial application, if the department does not notify the educational institution of any errors or omissions within the 30-day period; or

2. A revised application that corrects each error and omission of which the department notifies the educational institution within the 30-day period.

(b) Following the department's receipt of a complete program application, the board may conduct an onsite evaluation if necessary to document the applicant's compliance with subsection (1). Within 90 days after the department's receipt of a complete program application, the board shall:

1. Approve the application if it documents compliance with subsection (1); or

2. Provide the educational institution with a notice of intent to deny the application if it does not document compliance with subsection (1). The notice must specify written reasons for the board's denial of the application. The board may


698194

not deny a program application because of an educational institution's failure to correct an error or omission that the department failed to provide notice of to the institution within the 30-day notice period under paragraph (a). The educational institution may request a hearing on the notice of intent to deny the program application pursuant to chapter 120.

(c) A program application is deemed approved if the board does not act within the 90-day review period provided under paragraph (b).

(d) Upon the board's approval of a program application, the program becomes an approved program.

(e) The board shall deny an application from a program that has had adverse action taken against it by another regulatory jurisdiction in the United States. The board may also revoke the approval of an existing approved program that has had adverse action taken against it by another regulatory jurisdiction in the United States. For purposes of this paragraph, the term "adverse action" means any administrative, civil, or criminal action imposed by a licensing board or other state authority against a program. The term includes actions such as revocation, suspension, probation, or any other encumbrance affecting the program's authorization to operate.

(3) ANNUAL REPORT.—By November 1 of each year, each approved program's director ~~program~~ shall submit to the board an annual report consisting ~~comprised~~ of an affidavit certifying continued compliance with subsection (1), a summary description of the program's compliance with subsection (1), and documentation for the previous academic year that, to the extent applicable, describes:

698194

(a) The number of student applications received, qualified applicants, applicants accepted, accepted applicants who enroll in the program, students enrolled in the program, and program graduates.

(b) The program's retention rates for students tracked from program entry to graduation.

(c) The program's accreditation status, including identification of the accrediting agency.

The board must terminate the program pursuant to chapter 120 if the requirements of this subsection are not met. Upon request, the board may give an extension for good cause not to exceed 60 days for a program to meet the requirements of this subsection. If a program director is found to be in violation of this subsection, the board may impose a penalty listed in s. 456.072(2).

(4) INTERNET WEBSITE.—The board shall publish the following information on its Internet website:

(a) A list of each accredited program conducted in the state and the program's graduate passage rates for the most recent 2 calendar years, which the department shall determine through the following sources:

1. For a program's accreditation status, the specialized accrediting agencies that are nationally recognized by the United States Secretary of Education to accredit nursing education programs.

2. For a program's graduate passage rates, the contract testing service of the National Council of State Boards of Nursing.

698194

(b) The following data for each approved program, which includes, to the extent applicable:

1. All documentation provided by the program in its program application.

2. The summary description of the program's compliance submitted under subsection (3).

3. The program's accreditation status, including identification of the accrediting agency.

4. The program's probationary status.

5. The program's graduate passage rates for the most recent 2 calendar years.

6. Each program's retention rates for students tracked from program entry to graduation.

(c) The average passage rates for United States educated, first-time test takers on the National Council of State Boards of Nursing Licensing Examination for the most recent 2 calendar years, as calculated by the contract testing service of the National Council of State Boards of Nursing. The average passage rates shall be published separately for each type of comparable degree program listed in subparagraph (5)(a)1., and individually for each approved nursing program.

The information required to be published under this subsection shall be made available in a manner that allows interactive searches and comparisons of individual programs selected by the website user. The board shall update the Internet website at least quarterly with the available information.

(5) ACCOUNTABILITY.—

(a)1. An approved program must achieve a graduate passage


698194

rate for first-time test takers which is not more than 10 percentage points lower than the average passage rate during the same calendar year for graduates of comparable degree programs who are United States educated, first-time test takers on the National Council of State Boards of Nursing Licensing Examination, as calculated by the contract testing service of the National Council of State Boards of Nursing. For purposes of this subparagraph, an approved program is comparable to all degree programs of the same program type from among the following program types:

a. Professional nursing education programs that terminate in a bachelor's degree.

b. Professional nursing education programs that terminate in an associate degree.

c. Professional nursing education programs that terminate in a diploma.

d. Practical nursing education programs.

2. If an approved program's graduate passage rates do not equal or exceed the required passage rates for 2 consecutive calendar years, the board must ~~shall~~ place the program on probationary status pursuant to chapter 120 and the program director must submit a written remediation plan to the board. The program director must ~~shall~~ appear before the board to present the ~~a~~ plan for remediation, which must ~~shall~~ include specific nationally recognized benchmarks to identify progress toward a graduate passage rate goal. The board must terminate a program pursuant to chapter 120 if the program director fails to submit a written remediation plan or fails to appear before the board and present the remediation plan no later than 6 months


698194

after the date of the program being placed on probation. The board may impose a penalty listed in s. 456.072(2) on the program director for such failure. The program must remain on probationary status until it achieves a graduate passage rate that equals or exceeds the required passage rate for ~~any~~ 1 calendar year. The board must ~~shall~~ deny a program application for a new prelicensure nursing education program submitted by an educational institution if the institution has an existing program that is already on probationary status.

3. Upon the program's achievement of a graduate passage rate that equals or exceeds the required passage rate, the board, at its next regularly scheduled meeting following release of the program's graduate passage rate by the National Council of State Boards of Nursing, shall remove the program's probationary status. If the program, during the 2 calendar years following its placement on probationary status, does not achieve the required passage rate ~~for any 1 calendar year~~, the board must ~~may extend the program's probationary status for 1 additional year, provided the program has demonstrated adequate progress toward the graduate passage rate goal by meeting a majority of the benchmarks established in the remediation plan. If the program is not granted the 1-year extension or fails to achieve the required passage rate by the end of such extension, the board shall~~ terminate the program pursuant to chapter 120.

(b) If an approved program fails to submit the annual report required in subsection (3), the board must ~~shall~~ notify the program director and president or chief executive officer of the educational institution in writing within 15 days after the due date of the annual report. The program director must ~~shall~~


698194

appear before the board at the board's next regularly scheduled meeting to explain the reason for the delay. The board must ~~shall~~ terminate the program pursuant to chapter 120 if the program director fails to appear before the board, as required under this paragraph, or if the program does not submit the annual report within 6 months after the due date.

(c) A nursing education program, whether accredited or nonaccredited, which has been placed on probationary status must ~~shall~~ disclose its probationary status in writing to the program's students and applicants. The notification must include an explanation of the implications of the program's probationary status on the students or applicants.

(d) If students from a program that is terminated pursuant to this subsection transfer to an approved or an accredited program under the direction of the Commission for Independent Education, the board must ~~shall~~ recalculate the passage rates of the programs receiving the transferring students, excluding the test scores of those students transferring more than 12 credits.

(e) Duly authorized agents or employees of the department may conduct onsite evaluations or inspections at any time during business hours to ensure that approved programs or accredited programs are in full compliance with this chapter, or to determine whether this chapter or s. 456.072 is being violated. The department may collect any necessary evidence needed to ensure compliance with this chapter or for prosecution as deemed necessary. A failure of a program to refuse or allow an onsite evaluation or inspection is deemed a violation of a legal obligation imposed by the board or the department.

(6) DISCLOSURE OF GRADUATE PASSAGE RATE DATA.—

 698194

(a) For each graduate of the program included in the calculation of the program's graduate passage rate, the department shall disclose to the program director~~, upon his or her written request,~~ the name, examination date, and determination of whether each graduate passed or failed the National Council of State Boards of Nursing Licensing Examination, if such information is provided to the department by the contract testing service of the National Council of State Boards of Nursing. The department shall disclose to the program director the average passage rate for graduates from its program ~~written request must specify the calendar years for which the information is requested~~.

(b) A program director to whom confidential information exempt from public disclosure pursuant to s. 456.014 is disclosed under this subsection must maintain the confidentiality of the information and is subject to the same penalties provided in s. 456.082 for department employees who unlawfully disclose confidential information.

(c) The program director is responsible for ensuring that the graduate average passage rate, as reported by the department, is posted on the program's website.

(8) RULEMAKING.—The board does not have rulemaking authority to administer this section, except that the board shall adopt rules that prescribe the format for submitting program applications under subsection (1) and annual reports under subsection (3), to implement graduate nursing preceptorships as established in paragraph (1)(k), to enforce and administer subsection (5), and to administer the documentation of the accreditation of nursing education programs


698194

under subsection (11). The board may adopt rules relating to the nursing curriculum, including rules relating to the uses and limitations of simulation technology~~, and rules relating to the criteria to qualify for an extension of time to meet the accreditation requirements under paragraph (11)(f)~~. The board may not impose any condition or requirement on an educational institution submitting a program application, an approved program, or an accredited program, except as expressly provided in this section.

(11) ACCREDITATION REQUIRED.—

~~(f) An approved nursing education program may, no sooner than 90 days before the deadline for meeting the accreditation requirements of this subsection, apply to the board for an extension of the accreditation deadline for a period which does not exceed 2 years. An additional extension may not be granted. In order to be eligible for the extension, the approved program must establish that it has a graduate passage rate of 60 percent or higher on the National Council of State Boards of Nursing Licensing Examination for the most recent calendar year and must meet a majority of the board's additional criteria, including, but not limited to, all of the following:~~

~~1. A student retention rate of 60 percent or higher for the most recent calendar year.~~

~~2. A graduate work placement rate of 70 percent or higher for the most recent calendar year.~~

~~3. The program has applied for approval or been approved by an institutional or programmatic accreditor recognized by the United States Department of Education.~~

~~4. The program is in full compliance with subsections (1)~~

 698194

~~and (3) and paragraph (5)(b).~~

~~5. The program is not currently in its second year of probationary status under subsection (5).~~

~~The applicable deadline under this paragraph is tolled from the date on which an approved program applies for an extension until the date on which the board issues a decision on the requested extension.~~

Section 3. This act shall take effect July 1, 2025.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to nursing education programs; amending s. 464.008, F.S., requiring the Department of Health to issue provisional licenses to graduate licensed practical nurses and graduate registered nurses under the supervision of clinical preceptors; amending s. 464.019, F.S.; revising application requirements for nursing education program approval; providing preceptorship requirements; requiring the Florida Center for Nursing to develop graduate nursing preceptorship standards by a specified date; requiring the Board of Nursing to incorporate the standards into rule; clarifying that the Board of Nursing must publish the graduate average passage rate of each approved nursing program on its website; requiring the

698194

board to deny an application under certain circumstances; requiring the board to revoke an existing program's approval under certain circumstances; defining the term "adverse action"; revising requirements for annual reports approved programs are required to submit to the board; requiring the board to terminate a program under certain circumstances; providing penalties for program directors found to be in violation of specified provisions; revising remediation procedures for approved programs with graduate passage rates that do not meet specified requirements; subjecting program directors of approved programs to specified disciplinary action under certain circumstances; deleting a provision authorizing the board to extend a program's probationary status; authorizing agents or employees of the department to conduct onsite evaluations and inspections of approved and accredited nursing education programs; authorizing the department to collect evidence as part of such evaluations and inspections; deeming failure or refusal of a program to allow such evaluation or inspection as a violation of a legal obligation; requiring the department to disclose graduate average passage rates to each program director; providing that program directors are responsible for ensuring that graduate average passage rates are posted on the program's website; revising rulemaking authority of the board; deleting a provision authorizing approved nursing education

698194

programs to request an extension to meet the board's accreditation requirements; providing an effective date.

By the Committee on Health Policy; and Senator Harrell

588-02128-25 2025526c1

A bill to be entitled

An act relating to nursing education programs; amending s. 464.019, F.S.; revising application requirements for nursing education program approval; requiring the Board of Nursing to deny an application under certain circumstances; authorizing the board to revoke a program's approval under certain circumstances; revising requirements for annual reports approved programs are required to submit to the board; providing for the revocation of a program's approval, and discipline of its program director, under certain circumstances; revising remediation procedures for approved programs with graduate passage rates that do not meet specified requirements; subjecting program directors of approved programs to specified disciplinary action under certain circumstances; deleting a provision authorizing the board to extend a program's probationary status; authorizing agents of the Department of Health to conduct onsite evaluations and inspections of approved and accredited nursing education programs; authorizing the department to collect evidence as part of such evaluations and inspections; deeming failure or refusal of a program to allow such evaluation or inspection as a violation of a legal obligation; revising rulemaking authority of the board; deleting a provision authorizing approved nursing education programs to request an extension to meet the board's accreditation requirements; providing an effective

588-02128-25 2025526c1

date.

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

Section 1. Subsections (1), (2), (3), (5), and (8) and paragraph (f) of subsection (11) of section 464.019, Florida Statutes, are amended to read:

464.019 Approval of nursing education programs.—

(1) PROGRAM APPLICATION.—An educational institution that wishes to conduct a program in this state for the prelicensure education of professional or practical nurses must submit to the department a program application and review fee of $1,000 for each prelicensure nursing education program to be offered at the institution's main campus, branch campus, or other instructional site. The program application must include the legal name of the educational institution, the legal name of the nursing education program, the legal name of the nursing education program director, and, if such institution is accredited, the name of the accrediting agency. The application must also document that:

(a)1. For a professional nursing education program, the program director and at least 50 percent of the program's faculty members are registered nurses who have a master's or higher degree in nursing or a bachelor's degree in nursing and a master's or higher degree in a field related to nursing.

2. For a practical nursing education program, the program director and at least 50 percent of the program's faculty members are registered nurses who have a bachelor's or higher degree in nursing.

The educational degree requirements of this paragraph must ~~may~~ be documented by an official transcript or by a written statement from the program director of the educational institution verifying that the institution conferred the degree. The program director shall certify the official transcript or written statement as true and accurate.

(b) The program's nursing major curriculum consists of at least:

1. Fifty percent clinical training in the United States, the District of Columbia, or a possession or territory of the United States for a practical nursing education program, an associate degree professional nursing education program, or a professional diploma nursing education program.

2. Forty percent clinical training in the United States, the District of Columbia, or a possession or territory of the United States for a bachelor's degree professional nursing education program.

(c) No more than 50 percent of the program's clinical training consists of clinical simulation.

(d) The program has signed agreements with each agency, facility, and organization included in the curriculum plan as clinical training sites and community-based clinical experience sites.

(e) The program has written policies for faculty which include provisions for direct or indirect supervision by program faculty or clinical preceptors for students in clinical training consistent with the following standards:

1. The number of program faculty members equals at least one faculty member directly supervising every 12 students unless

the written agreement between the program and the agency, facility, or organization providing clinical training sites allows more students, not to exceed 18 students, to be directly supervised by one program faculty member.

2. For a hospital setting, indirect supervision may occur only if there is direct supervision by an assigned clinical preceptor, a supervising program faculty member is available by telephone, and such arrangement is approved by the clinical facility.

3. For community-based clinical experiences that involve student participation in invasive or complex nursing activities, students must be directly supervised by a program faculty member or clinical preceptor and such arrangement must be approved by the community-based clinical facility.

4. For community-based clinical experiences not subject to subparagraph 3., indirect supervision may occur only when a supervising program faculty member is available to the student by telephone.

A program's policies established under this paragraph must require that a clinical preceptor who is supervising students in a professional nursing education program be a registered nurse or, if supervising students in a practical nursing education program, be a registered nurse or licensed practical nurse.

(f) The professional or practical nursing curriculum plan documents clinical experience and theoretical instruction in medical, surgical, obstetric, pediatric, and geriatric nursing. A professional nursing curriculum plan must ~~shall~~ also document clinical experience and theoretical instruction in psychiatric

nursing. Each curriculum plan must document clinical training experience in appropriate settings that include, but are not limited to, acute care, long-term care, and community settings.

(g) The professional or practical nursing education program provides theoretical instruction and clinical application in personal, family, and community health concepts; nutrition; human growth and development throughout the life span; body structure and function; interpersonal relationship skills; mental health concepts; pharmacology and administration of medications; and legal aspects of practice. A professional nursing education program must also provide theoretical instruction and clinical application in interpersonal relationships and leadership skills; professional role and function; and health teaching and counseling skills.

(h) The professional or practical nursing education program has established evaluation and standardized admission criteria. The admission criteria must, at a minimum, identify those students who are likely to need additional educational support to be successful program graduates. The program must maintain documentation of the individualized student academic support plan for those students identified as in need of additional preparation and educational support.

(i) The professional or practical nursing education program has an established comprehensive examination to prepare students for the National Council of State Boards of Nursing Licensing Examination (NCLEX). The comprehensive examination must be termed an exit examination that all programs will administer and may not be the sole exclusion to graduation if the student has otherwise successfully completed all coursework required by the

program. The program director is responsible for ensuring that the average exit examination results of the program are placed on the program's website and reported to the board along with the annual report required in subsection (3).

(j) The professional or practical nursing education program has submitted to the board the established criteria for remediation that will be offered to students who do not successfully pass the exit examination. A program with NCLEX passage rates at least 10 percentage points below the average passage rate for the most recent calendar year must offer remediation at no additional cost or refer the student to an approved remedial program and pay for that program for the student.

(2) PROGRAM APPROVAL.—

(a) Upon receipt of a program application and review fee, the department shall examine the application to determine if it is complete. If the application is not complete, the department must ~~shall~~ notify the educational institution in writing of any errors or omissions within 30 days after the department's receipt of the application. A program application is deemed complete upon the department's receipt of:

1. The initial application, if the department does not notify the educational institution of any errors or omissions within the 30-day period; or

2. A revised application that corrects each error and omission of which the department notifies the educational institution within the 30-day period.

(b) Following the department's receipt of a complete program application, the board may conduct an onsite evaluation

if necessary to document the applicant's compliance with subsection (1). Within 90 days after the department's receipt of a complete program application, the board shall:

1. Approve the application if it documents compliance with subsection (1); or

2. Provide the educational institution with a notice of intent to deny the application if it does not document compliance with subsection (1). The notice must specify written reasons for the board's denial of the application. The board may not deny a program application because of an educational institution's failure to correct an error or omission that the department failed to provide notice of to the institution within the 30-day notice period under paragraph (a). The educational institution may request a hearing on the notice of intent to deny the program application pursuant to chapter 120.

(c) A program application is deemed approved if the board does not act within the 90-day review period provided under paragraph (b).

(d) Upon the board's approval of a program application, the program becomes an approved program.

(e) The board shall deny an application from a program that has had adverse action taken against it by another regulatory jurisdiction in the United States. The board may also revoke the approval of an existing approved program that has had adverse action taken against it by another regulatory jurisdiction in the United States.

(3) ANNUAL REPORT.—By November 1 of each year, each approved program's director ~~program~~ shall submit to the board an annual report comprised of an affidavit certifying continued

compliance with subsection (1), a summary description of the program's compliance with subsection (1), and documentation for the previous academic year that, to the extent applicable, describes:

(a) The number of student applications received, qualified applicants, applicants accepted, accepted applicants who enroll in the program, students enrolled in the program, and program graduates.

(b) The program's retention rates for students tracked from program entry to graduation.

(c) The program's accreditation status, including identification of the accrediting agency.

The board must terminate the program pursuant to chapter 120 if the requirements of this subsection are not met. The program director is also subject to discipline under s. 456.072(1)(k) for such failure.

(5) ACCOUNTABILITY.—

(a)1. An approved program must achieve a graduate passage rate for first-time test takers which is not more than 10 percentage points lower than the average passage rate during the same calendar year for graduates of comparable degree programs who are United States educated, first-time test takers on the National Council of State Boards of Nursing Licensing Examination, as calculated by the contract testing service of the National Council of State Boards of Nursing. For purposes of this subparagraph, an approved program is comparable to all degree programs of the same program type from among the following program types:

a. Professional nursing education programs that terminate in a bachelor's degree.

b. Professional nursing education programs that terminate in an associate degree.

c. Professional nursing education programs that terminate in a diploma.

d. Practical nursing education programs.

2. If an approved program's graduate passage rates do not equal or exceed the required passage rates for 2 consecutive calendar years, the board must ~~shall~~ place the program on probationary status pursuant to chapter 120 and the program director must submit a written remediation plan to the board. The program director must ~~shall~~ appear before the board to present the ~~a~~ plan for remediation, which must ~~shall~~ include specific nationally recognized benchmarks to identify progress toward a graduate passage rate goal. The board must terminate a program pursuant to chapter 120 if the program director fails to submit a written remediation plan or fails to appear before the board and present the remediation plan no later than 6 months after the date of the program being placed on probation. The program's director is also subject to discipline under s. 456.072(1)(k) for such failure. The program must remain on probationary status until it achieves a graduate passage rate that equals or exceeds the required passage rate for ~~any~~ 1 calendar year. The board must ~~shall~~ deny a program application for a new prelicensure nursing education program submitted by an educational institution if the institution has an existing program that is already on probationary status.

3. Upon the program's achievement of a graduate passage

rate that equals or exceeds the required passage rate, the board, at its next regularly scheduled meeting following release of the program's graduate passage rate by the National Council of State Boards of Nursing, shall remove the program's probationary status. If the program, during the 2 calendar years following its placement on probationary status, does not achieve the required passage rate ~~for any 1 calendar year~~, the board must ~~may extend the program's probationary status for 1 additional year, provided the program has demonstrated adequate progress toward the graduate passage rate goal by meeting a majority of the benchmarks established in the remediation plan. If the program is not granted the 1-year extension or fails to achieve the required passage rate by the end of such extension, the board shall~~ terminate the program pursuant to chapter 120.

(b) If an approved program fails to submit the annual report required in subsection (3), the board must ~~shall~~ notify the program director and president or chief executive officer of the educational institution in writing within 15 days after the due date of the annual report. The program director must ~~shall~~ appear before the board at the board's next regularly scheduled meeting to explain the reason for the delay. The board must ~~shall~~ terminate the program pursuant to chapter 120 if the program director fails to appear before the board, as required under this paragraph, or if the program does not submit the annual report within 6 months after the due date.

(c) A nursing education program, whether accredited or nonaccredited, which has been placed on probationary status must ~~shall~~ disclose its probationary status in writing to the program's students and applicants. The notification must include

an explanation of the implications of the program's probationary status on the students or applicants.

(d) If students from a program that is terminated pursuant to this subsection transfer to an approved or an accredited program under the direction of the Commission for Independent Education, the board must ~~shall~~ recalculate the passage rates of the programs receiving the transferring students, excluding the test scores of those students transferring more than 12 credits.

(e) Duly authorized agents or employees of the department may conduct onsite evaluations or inspections at all reasonable hours to ensure that approved programs or accredited programs are in full compliance with this chapter, or to determine whether this chapter or s. 456.072 is being violated. The department may collect any necessary evidence needed to ensure compliance with this chapter or for prosecution as deemed necessary. A failure of a program to refuse or allow an onsite evaluation or inspection is deemed a violation of a legal obligation imposed by the board or the department.

(8) RULEMAKING.—The board does not have rulemaking authority to administer this section, except that the board shall adopt rules that prescribe the format for submitting program applications under subsection (1) and annual reports under subsection (3), to enforce and administer subsection (5), and to administer the documentation of the accreditation of nursing education programs under subsection (11). The board may adopt rules relating to the nursing curriculum, including rules relating to the uses and limitations of simulation technology~~,~~ ~~and rules relating to the criteria to qualify for an extension of time to meet the accreditation requirements under paragraph~~

~~(11)(f)~~. The board may not impose any condition or requirement on an educational institution submitting a program application, an approved program, or an accredited program, except as expressly provided in this section.

(11) ACCREDITATION REQUIRED.—

~~(f) An approved nursing education program may, no sooner than 90 days before the deadline for meeting the accreditation requirements of this subsection, apply to the board for an extension of the accreditation deadline for a period which does not exceed 2 years. An additional extension may not be granted. In order to be eligible for the extension, the approved program must establish that it has a graduate passage rate of 60 percent or higher on the National Council of State Boards of Nursing Licensing Examination for the most recent calendar year and must meet a majority of the board's additional criteria, including, but not limited to, all of the following:~~

~~1. A student retention rate of 60 percent or higher for the most recent calendar year.~~

~~2. A graduate work placement rate of 70 percent or higher for the most recent calendar year.~~

~~3. The program has applied for approval or been approved by an institutional or programmatic accreditor recognized by the United States Department of Education.~~

~~4. The program is in full compliance with subsections (1) and (3) and paragraph (5)(b).~~

~~5. The program is not currently in its second year of probationary status under subsection (5).~~

~~The applicable deadline under this paragraph is tolled from the~~

~~date on which an approved program applies for an extension until the date on which the board issues a decision on the requested extension.~~

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

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	CS/SB 614
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Polsky
SUBJECT:	Public Education of Background Screening Requirements
DATE:	April 14, 2025 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 614 requires the Agency for Health Care Administration (AHCA), in coordination with other specified agencies, to launch a user-friendly, public-facing webpage by January 1, 2026, that serves as a centralized hub for background screening education and awareness.

The site must explain the Care Provider Background Screening Clearinghouse process, Level 2 screening requirements, fingerprinting procedures, and include a searchable job catalog, disqualifying offenses, exemption steps, and a downloadable checklist.

Additionally, the bill requires all specified agencies to prominently link to this resource from their websites and encourage the inclusion of the link in job postings. Annual updates are required by October 1.

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

This bill takes effect July 1, 2025.

II. Present Situation:

Criminal Background Screening

Criminal background screening plays a key role in protecting vulnerable populations such as children, individuals with disabilities, and the elderly. The Florida Department of Law Enforcement (FDLE) operates the Care Provider Background Screening Clearinghouse, which handles fingerprint-based background checks for individuals applying to work in various care settings. These screenings include both state and federal criminal history checks. Level 2 screening includes, but is not limited to, fingerprinting for statewide criminal history records checks through the FDLE, and national criminal history records checks through the Federal Bureau of Investigation (FBI).[1]

Various state agencies require background screenings depending on the population served. For example, the Department of Children and Families (DCF) mandates screenings for individuals working in childcare facilities, foster care, adoption agencies, and certain recreational programs.[2] The Agency for Health Care Administration (AHCA) also plays a role in oversight, particularly for health care providers.[3] Other agencies include the Department of Health (DOH), the Department of Elder Affairs (DOEA), the Department of Juvenile Justice (DJJ), the Agency for Persons with Disabilities (APD), and the Department of Education (DOE) and specific entities, including school districts, special districts, the Florida School for the Deaf and the Blind, the Florida Virtual School, charter schools and alternative schools, workforce boards, and local licensing agencies, when these agencies are conducting state and national criminal history background screening on persons who work with children or persons who are elderly or disabled.[4]

To ensure accountability, statute enforces strict penalties for noncompliance. Programs that fail to screen personnel or knowingly retain individuals with disqualifying offenses may face legal action.[5] Under s. 409.175(12), F.S., such violations can result in first-degree misdemeanor or third-degree felony charges, depending on the circumstances.[6]

Chapter 435, F.S., sets the legal standards for background screening of individuals in positions of trust, particularly those working with vulnerable populations. It outlines Level 1 (state-only) and Level 2 (state and federal fingerprint-based) screenings:

- **Level 1**: Screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement

[1] Section 435.01, F.S.
[2] Department of Children and Families, *Background Screening*, available at https://www.myflfamilies.com/services/background-screening (last visited March 26, 2025).
[3] Agency for Health Care Administration, *Background Screening*, available at https://ahca.myflorida.com/health-quality-assurance/bureau-of-central-services/background-screening (last visited March 26, 2025).
[4] Section 435.02(7), F.S.
[5] Section 409.175, F.S.
[6] *Id.*

(FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[7] and may include criminal records checks through local law enforcement agencies.[8,9]

- **Level 2**: Screening includes, at a minimum, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[10]

Florida law prohibits anyone, including individuals, agencies, foster homes, and children's camps, from using criminal or juvenile record information obtained through background screening for anything other than employment decisions.[11]

Disqualifying Offenses

Disqualifying offense refers to a criminal conviction that legally bars an individual from employment in certain positions of trust or care, particularly those involving vulnerable populations such as children, the elderly, or persons with disabilities.[12] If a person has been convicted of a disqualifying offense, they are generally ineligible for employment in licensed facilities or programs unless they obtain an exemption from disqualification.[13] Employers are prohibited from hiring individuals with these offenses unless a formal exemption is granted by the appropriate agency.[14] Disqualifying offenses include:

Statute	Offense Description
39.205	Failure to report child abuse, abandonment, or neglect
393.135	Sexual misconduct with developmentally disabled clients
394.4593	Sexual misconduct with mental health patients
414.39	Public assistance fraud (felony)
415.111	Abuse, neglect, or exploitation of aged or disabled adults
777.04	Attempts, solicitation, and conspiracy to commit listed offenses
782.04	Murder
782.07	Manslaughter and aggravated manslaughter
782.071	Vehicular homicide
782.09	Killing of unborn child by injury to mother
Chapter 784	Felony assault, battery, or culpable negligence
784.011	Assault (victim was a minor)
784.021	Aggravated assault
784.03	Battery (victim was a minor)
784.045	Aggravated battery

[7] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site, www.nsopw.gov (last visited March 26, 2025).
[8] Department of Law Enforcement, *State of Florida Criminal History Records Check*, http://www.fdle.state.fl.us/Criminal-History-Records/Florida-Checks.aspx (last visited March 26, 2025).
[9] Section 435.03, F.S.
[10] Section 435.04, F.S.
[11] Section 409.175(12), F.S.
[12] Section 435.01, F.S.
[13] Section 435.07, F.S.
[14] Section 435.06, F.S.

Statute	Offense Description
784.075	Battery on facility staff or juvenile probation officer
787.01	Kidnapping
787.02	False imprisonment
787.025	Luring or enticing a child
787.04(2)	Interfering with custody—taking child beyond state lines
787.04(3)	Avoiding custody hearing—taking child beyond state lines
787.06	Human trafficking
787.07	Human smuggling
790.115(1)	Exhibiting firearms or weapons within 1,000 feet of school
790.115(2)(b)	Possessing weapons on school property
794.011	Sexual battery
794.041	Prohibited acts by persons in familial/custodial authority
794.05	Unlawful sexual activity with certain minors
794.08	Female genital mutilation
Chapter 796	Prostitution-related offenses
798.02	Lewd and lascivious behavior
Chapter 800	Lewdness and indecent exposure
806.01	Arson
810.02	Burglary
810.14	Voyeurism (felony)
810.145	Video voyeurism (felony)
Chapter 812	Theft, robbery, and related crimes (felony)
817.563	Fraudulent sale of controlled substances (felony)
825.102	Abuse or neglect of elderly or disabled adult
825.1025	Lewd acts upon elderly or disabled adult
825.103	Exploitation of elderly or disabled adult (felony)
826.04	Incest
827.03	Child abuse or neglect
827.04	Contributing to delinquency or dependency of a child
827.05	Negligent treatment of children (former statute)
827.071	Sexual performance by a child
831.311	Counterfeit-resistant prescription blanks
836.10	Threats of violence or terrorism
843.01	Resisting arrest with violence
843.025	Depriving officer of communication or protection
843.12	Aiding in an escape
843.13	Aiding juvenile inmate escape
Chapter 847	Obscene literature
859.01	Poisoning food or water
873.01	Illegal sale or purchase of human organs or tissue
874.05	Gang recruitment or encouragement
Chapter 893	Drug offenses (felony or involving minors)
916.1075	Sexual misconduct with forensic clients
944.35(3)	Cruel treatment of inmate causing great bodily harm

Statute	Offense Description
944.40	Escape
944.46	Aiding escaped prisoner
944.47	Introducing contraband into correctional facility
985.701	Sexual misconduct in juvenile programs
985.711	Contraband in detention facilities

Exemptions

An exemption from disqualification in Florida allows individuals who have been disqualified from employment due to a criminal offense to request permission to work in positions requiring background screening, despite their criminal history.[15] According to statute, the licensing agency may grant to any employee otherwise disqualified from employment an exemption from disqualification for employment or permission to work solely in a nonclient-facing role if certain criteria are met.[16] The exemptions are as follows:[17]

- Two years have elapsed since the individual has completed or been lawfully released from confinement supervision, or nonmonetary condition imposed by a court for a disqualifying felony; or
- The individual has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by a court for a misdemeanor or an offense that was a felony at the time of commission but is now a misdemeanor.

Exemptions from disqualification are not available for individuals convicted of certain serious criminal offenses such as sexual misconduct with children, murder, kidnapping, human trafficking, and other violent or sexually explicit offenses involving vulnerable populations unless a specific statutory provision allows it.[18] These offenses are viewed as incompatible with positions of trust or care, particularly those involving children, the elderly, or persons with disabilities.[19]

Care Provider Background Screening Clearinghouse

The Care Provider Background Screening Clearinghouse (Clearinghouse) was first authorized in 2010 to create a centralized system for background screening across multiple health and human services agencies.[20] Prior to the Clearinghouse, individuals working with vulnerable populations, such as children, the elderly, or persons with disabilities, who often had to undergo separate background checks for each agency or employer, even within similar roles. This resulted in unnecessary delays, duplication of efforts, and increased costs for providers and the state.

The Clearinghouse was formally launched and began operations in 2012 in coordination with the AHCA and other state agencies.[21] The statute authorizes the AHCA to implement and maintain

[15] Section 435.07(1), F.S.
[16] *Id.*
[17] Section 435.07, F.S.
[18] Section 435.07(4), F.S.
[19] Section 431.01, F.S.
[20] Section 435, F.S.
[21] Section 435.12, F.S.

the Clearinghouse in coordination with other state agencies, including the DCF, the DOH, the DOEA, the APD, the DJJ, and the DOE.[22]

The Clearinghouse allows these agencies to access and share background screening results and eligibility determinations for individuals working or seeking to work in positions that require screening.[23] Authorized employers and state agencies can access screening results and eligibility decisions in real time, helping speed up hiring and licensing.[24] Each screening includes a photo to verify the person's identity.[25] All screenings are Level 2 background checks, which include fingerprinting and checks with the FDLE, the FBI, and state abuse registries.[26] The Clearinghouse stores fingerprints for up to five years using the FDLE Civil Workflow Control System (CWCS) and allows for easy rescreening and ongoing monitoring.[27] The Clearinghouse ensures regulatory compliance, prevents unnecessary duplication, and supports continuity across sectors while maintaining the integrity and security of screening information.

III. Effect of Proposed Changes:

Section 1 amends s. 435.12, F.S., to require the Agency for Health Care Administration (AHCA), in coordination with other specified agencies, to create a public-facing webpage that serves as a centralized hub for background screening education and awareness. This webpage must be accessible, non-technical, and tailored to qualified entities.

The webpage must explain how the Care Provider Background Screening Clearinghouse works, clarify Level 2 screening requirements, and outline procedures for live-scan fingerprinting, including vendor information and estimated costs. It must also feature a searchable catalog listing all employment positions legally subject to screening, identifying disqualifying offenses and outlining the exemption process.

The site must provide a downloadable checklist that summarizes key steps, timelines, and agency contacts related to the screening process. Additionally, the bill requires all specified agencies to prominently link to this resource from their websites and encourage the inclusion of the link in job postings.

The webpage must go live by January 1, 2026, and be updated annually by October 1 to reflect changes in law or process.

Section 2 provides the bill takes effect July 1, 2025.

[23] Section 435.12(1), F.S.
[23] Section 435.12(1), F.S.
[24] *Id.*
[25] Section 435.12(2)(c), F.S.
[26] Section 435.04, F.S.
[27] Rule 59A-35.090, F.A.C.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None Identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None

C. Government Sector Impact:

The bill will have an insignificant, negative fiscal impact on state expenditures that can be absorbed within existing resources for the development, operation, and annual updating of a publicly accessible webpage as part of the Care Provider Background Screening Clearinghouse explaining background screening requirements and procedures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 435.12 of the Florida Statutes.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs Committee on April 1, 2025:
The CS requires the Agency for Health Care Administration, in consultation with the Department of Law Enforcement and other specified agencies to:

- Develop and maintain a publicly available webpage as part of the existing Care Provider Background Screening Clearinghouse (Clearinghouse) system.
- Website must include clear, non-technical information tailored to qualified entities about background screening requirements.
  - Details on Level 2 background screening, the Clearinghouse and Live scan fingerprinting or similar system.
  - A searchable catalog, organized by agency, listing job classes/positions required to undergo screening, list of disqualifying offenses, exemption requirements and process, downloadable checklist outlining the screening process, timelines, and contact information, tailored for qualified entities.
- Each involved agency must provide a clear and conspicuous link to the webpage on their own websites and include the link in job vacancy ads and posts.
- Website must be live by January 1, 2026, and be reviewed and updated annually by October 1.

B. Amendments:

None.

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

586-03173A-25 2025614c1

A bill to be entitled

An act relating to public education of background screening requirements; amending s. 435.12, F.S.; requiring the Agency for Health Care Administration and the Department of Law Enforcement, in consultation with certain agencies, to develop and maintain a care provider background screening education and awareness webpage; providing requirements for resources provided on the webpage; requiring that specified agencies provide a link to the webpage on their respective websites and promote the inclusion of the link in certain media; requiring that the webpage be active by a specified date and updated annually; providing an effective date.

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

Section 1. Subsection (4) is added to section 435.12, Florida Statutes, to read:

435.12 Care Provider Background Screening Clearinghouse.—

(4)(a) As part of the Care Provider Background Screening Clearinghouse, the Agency for Health Care Administration, in consultation with all specified agencies that are required by law to use the clearinghouse for employment screening, must develop and maintain a publicly available webpage which provides a central source for care provider background screening education and awareness. This webpage may be part of the current web-based clearinghouse system. The resources available on the webpage must be written in nontechnical and accessible language,

586-03173A-25 2025614c1

tailored to qualified entities as defined in s. 943.0542(1)(b) and include, but need not be limited to:

1. Information and education related to employment screening requirements of qualified entities, to include:

a. The Care Provider Background Screening Clearinghouse.

b. Level 2 screening standards under chapter 435.

c. Live-scan fingerprinting, or other third-party systems, including information on process, vendors, locations, and potential costs.

2. A searchable catalog, by specified agency, of qualified entity employment classes and positions required by law to undergo employment screening through the clearinghouse, to include:

a. Disqualifying offenses.

b. Exemption requirements and process.

3. A downloadable checklist detailing the process, timelines, and contact information for employment screening process support, tailored to qualified entities.

(b) Specified agencies must include a clear and conspicuous link to the webpage on their respective websites and promote the inclusion of the link in all job vacancy advertisements and posts by qualified entities.

(c) The webpage must be active by January 1, 2026, and reviewed and updated by October 1, 2026, and each subsequent year to incorporate any changes to law, the clearinghouse, or the employment screening process.

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

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	SB 890
INTRODUCER:	Senator Yarborough
SUBJECT:	Improving Screening for and Treatment of Blood Clots
DATE:	April 14, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.	Gerbrandt	McKnight	AHS	**Pre-meeting**
3.			FP	

I. Summary:

SB 890 amends current law to improve screening for and treatment of blood clots. Specifically, the bill:

- Specifies that chronic critical illness and genetic predisposition for developing blood clots and pulmonary embolisms are chronic diseases.
- Requires the Department of Health (DOH) to create a blood clot and pulmonary embolism registry ;
- Requires specified training and protocols to screen a patient for the risk of blood clots, pulmonary embolism, or deep vein thrombosis (DVT) when the patient is admitted to a hospital or ambulatory surgical center (ASC) that provides specified services;
- Requires certified nursing assistants (CNA) serving in a nursing home to receive training on recognizing the signs and symptoms of a blood clot, pulmonary embolism, or DVT and techniques for providing an emergency response;
- Requires the Agency for Health Care Administration's (AHCA) rules for assisted living facilities (ALF) to include requirements for the identification of residents at risk for developing blood clots and for the treating facility's response protocols to ensure timely treatment; and
- Requires the AHCA to include training on the identification of and response to residents at high risk of developing blood clots and pulmonary embolisms in the core training required for all ALF administrators.

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

The bill takes effect July 1, 2025.

II. Present Situation:

Blood Clots

Blood clotting, or coagulation, is an important process that prevents excessive bleeding when a blood vessel is injured. Platelets (a type of blood cell) and proteins in plasma (the liquid part of blood) work together to stop the bleeding by forming a clot over the injury. Typically, the human body will naturally dissolve the blood clot after the injury has healed.

Sometimes, however, blood clots form on the inside of vessels without an obvious injury or do not dissolve naturally. These situations can be dangerous and require accurate diagnosis and appropriate treatment.

Clots can occur in veins or arteries, which are vessels that are part of the body's circulatory system. While both types of vessels help transport blood throughout the body, they each function differently. Veins are low-pressure vessels that carry deoxygenated blood away from the body's organs and back to the heart. An abnormal clot that forms in a vein may restrict the return of blood to the heart and can result in pain and swelling as the blood gathers behind the clot.

Deep Vein Thrombosis (DVT) is a type of clot that forms in a major vein of the leg or, less commonly, in the arms, pelvis, or other large veins in the body. In some cases, a clot in a vein may detach from its point of origin and travel through the heart to the lungs where it becomes wedged, preventing adequate blood flow. This is called a pulmonary (lung) embolism and can be extremely dangerous.

It is estimated that each year DVT affects as many as 900,000 people in the United States and kills up to 100,000.[1]

Blood Clots and Genetics

Thrombophilia is a medical term used to describe the condition where the blood has an increased tendency to clot. There are many reasons why the blood can have this increased tendency. Thrombophilia is usually categorized into two types–acquired and inherited. In acquired thrombophilia the abnormal clotting is usually related to a specific cause, such as prolonged periods of bed rest after surgery, trauma to the leg, or having cancer. People with inherited thrombophilia tend to form clots due to a genetic predisposition inherited from their parents. People with inherited thrombophilia may have a family history of relatives with abnormal or excessive blood clotting.

Blood clotting proteins, like all proteins, are made by linking together a chain of chemicals called amino acids. The order of the amino acids in the chain make up a specific protein; this order is determined by genes. While there are a number of mutations that can cause inherited

[1] American Society of Hematology, *Blood Clots*, available at https://www.hematology.org/education/patients/blood-clots, (last visited March 7, 2025).

thrombophilia, the most common deoxyribose nucleic acid (DNA) mutations are named factor V Leiden and prothrombin G20210A.[2]

Factor V Leiden

Human bodies produce a protein called factor V that helps blood clot. However, there are certain individuals who have a DNA mutation in the gene used to make the factor V protein. These individuals are said to have the "factor V Leiden" mutation.

Normally the factor V protein is produced to help the blood clot and is produced in greater amounts after a blood vessel is damaged. The amount of factor V protein produced is controlled by other proteins, including protein C and protein S. Protein C and protein S combine to help break up factor V, thus preventing it from being reused and clotting the blood.

When a person has factor V Leiden, the mutation causes the protein to be abnormally shaped. This abnormal shape prevents it from being broken down properly by proteins C and S. Since the factor V protein is not broken down, it is left in the blood for a longer period of time and increases the tendency for clotting.

It is estimated that about five percent of Caucasians have factor V Leiden, and it is more common in individuals of European ancestry. In the United States, approximately one to two percent of African Americans, Hispanic Americans, and Native Americans also have the mutation. Factor V Leiden is rare in people of Asian decent.[3]

Prothrombin G20210A Mutation

All individuals make the prothrombin (also called factor two) protein that helps blood clot. However, there are certain individuals who have a DNA mutation in the gene used to make prothrombin called the prothrombin G20210A or the factor II mutation.

Normally, the prothrombin protein is produced to help the blood clot and is produced in greater amounts after a blood vessel is damaged. People who have a mutation in the prothrombin gene produce more prothrombin protein than is normal. Since there is more of the prothrombin protein in the blood, this increases the tendency for clotting.

A change in the prothrombin gene is present in two to four percent of Caucasians and is more common in individuals of European ancestry. In the United States, approximately 0.4 percent of African Americans also have the mutation. Prothrombin G20210A mutation is rare in other demographic groups.

Deep Vein Thrombosis

DVT occurs when a blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs. Deep vein thrombosis can cause leg pain or swelling. Sometimes there are no noticeable symptoms.

[2] National Blood Clot Alliance, *The Genetics of Thrombophilia,* Elizabeth Varga, available at https://www.stoptheclot.org/about-clots/thrombophilia/genetics-of-thrombophilia/, (last visited March 7, 2025).
[3] Id.

Persons can get DVT if they have certain medical conditions that affect how the blood clots. A blood clot in the legs can also develop if a person doesn't move for a long time, e.g. sitting for an extended period while traveling a long distance or when a person is on bed rest due to surgery, an illness, or an accident.

Deep vein thrombosis can be serious because blood clots in the veins can break loose. The clots can then travel through the bloodstream and get stuck in the lungs, blocking blood flow (pulmonary embolism). When DVT and pulmonary embolism occur together, it's called venous thromboembolism (VTE).

Many things can increase the risk of developing DVT. The more risk factors are involved, the greater the risk of DVT. Risk factors for DVT include:

- **Age.** Being older than 60 increases the risk of DVT, but DVT can occur at any age.
- **Lack of movement.** Muscle contractions help blood flow. Sitting for a long time, such as when driving or flying, increases the risk of DVT. So does long-term bed rest, which may result from a lengthy hospital stay or a medical condition such as paralysis.
- **Injury or surgery.** Injury to the veins or surgery can increase the risk of blood clots.
- **Pregnancy.** Pregnancy increases the pressure in the veins in the pelvis and legs. The risk of blood clots from pregnancy can continue for up to six weeks after a baby is born. People with an inherited clotting disorder are especially at risk.
- **Birth control pills (oral contraceptives) or hormone replacement therapy.** Both can increase the blood's ability to clot.
- **Being overweight or obese.** Being overweight increases the pressure in the veins in the pelvis and legs.
- **Smoking.** Smoking affects how blood flows and clots, which can increase the risk of DVT.
- **Cancer.** Some cancers increase substances in the blood that cause the blood to clot. Some types of cancer treatment also increase the risk of blood clots.
- **Heart failure.** Heart failure increases the risk of DVT and pulmonary embolism.
- **Inflammatory bowel disease.** Crohn's disease or ulcerative colitis increase the risk of DVT.
- **A personal or family history of DVT or pulmonary embolism.** A person with a family history of these conditions might be at greater risk of developing DVT.
- **Genetics.** Some people have DNA changes that cause the blood to clot more easily.[4]

III. Effect of Proposed Changes:

The bill makes changes related to blood clots.

Section 1 amends s. 385.102, F.S., relating to the list of chronic diseases[5] that exist in high proportions among people of this state, to add "chronic critical illness" and "genetic predisposition for developing blood clots and pulmonary embolisms." The bill also updates the term "chronic obstructive lung disease" to "chronic obstructive pulmonary disease."

[4] Mayo Clinic, *Deep Vein Thrombosis*, June 11, 2022, available at https://www.mayoclinic.org/diseases-conditions/deep-vein-thrombosis/symptoms-causes/syc-20352557, (last visited March 7, 2025).
[5] The list contains diseases that must be included as chronic diseases under ch. 385, F.S., but is not exclusive.

Section 2 creates s. 385.213, F.S., to require the Department of Health (DOH) to establish, or contract with a recognized medical organization in Florida and its affiliated institutions, to establish a statewide blood clot and pulmonary embolism registry (registry) to ensure that blood clot and pulmonary embolism reports are maintained and available for use in the course of research for the purpose of reducing morbidity and mortality. The bill specifies that hospitals are immune from liability for having provided information to the DOH for inclusion in the registry.

The bill requires each facility licensed under chs. 395[6] or 408,[7] F.S., to report to the DOH the following information for each instance of a blood clot, pulmonary embolism, or deep vein thrombosis (DVT) identified in a patient:

- The number of blood clots, pulmonary embolisms, and deep vein thromboses identified and diagnosed.
- The age of the patient.
- The zip code of the patient.
- The sex of the patient.
- Whether the patient is a resident of a licensed nursing home or assisted living facility.
- Whether the blood clot, pulmonary embolism, or deep vein thrombosis was fatal.
- How the diagnosis was made, such as by using imaging modalities.
- The treatment that was recommended for the blood clot, pulmonary embolism, or deep vein thrombosis, as applicable.

The bill allows the DOH, by rule, to further specify what information is to be provided.

The bill specifies that the DOH, or the contractor operating the registry, may use or publish information from the registry only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a de-identified summary of the information contained in the registry may be released for general publication.

The bill also creates a public records exemption, making the records confidential and exempt, for personal identifying information held in the registry, except that:

- Such information may be released with the express written consent of the person or his or her legally authorized representative;
- The DOH or the contractor may contact individuals for the purpose of epidemiologic investigation and monitoring, provided such information that is confidential is not further disclosed; and
- The DOH may exchange data that includes personal identifying information with any other governmental agency or the contractor for the purpose of medical or scientific research, provided such governmental agency or contractor does not further disclose information that is confidential and exempt.

The bill specifies that any funds appropriated for implementation of the registry must be used for establishing, administering, compiling, processing, and providing biometric and statistical analyses to the reporting facilities. Funds may also be used to ensure the quality and accuracy of the information reported and to provide management information to the reporting facilities.

[6] Hospitals and ambulatory surgical centers.
[7] The list of facility types licensed pursuant to ch. 408, F.S., is in s. 408.802, F.S.

The bill allows the DOH, by rule, to classify facilities for purposes of reports made to the registry and specify the content and frequency of the reports. In classifying facilities, the DOH must exempt certain facilities from reporting blood clot and pulmonary embolism information that was previously reported to the DOH or retrieved from existing state reports made to the DOH or the Agency for Health Care Administration (AHCA).

The bill also exempts any facility from reporting to the registry if the primary purpose of the facility is to provide psychiatric care.

Section 3 creates s. 395.3042, F.S., to require hospitals and ambulatory surgical centers that provide emergency room services, orthopedic services, pregnancy services, or cancer treatment, to arrange for the rendering of appropriate medical attention for persons at risk for blood clots, pulmonary embolisms, or DVT as follows:

- Upon admission to such a facility, a patient must be assessed for risk of blood clots, pulmonary embolisms, and DVT using a nationally recognized risk assessment tool.
- The training of all staff in the facility must include continuing education annually on how to recognize a blood clot, pulmonary embolism, or DVT.
- The facility must have established protocols for staff to ensure that patients diagnosed with a life-threatening blood clot, pulmonary embolism, or DVT are assessed for various treatment options.
- The facility must have an established policy in place requiring a follow-up for all orthopedic patients who have undergone lower extremity or pelvic surgery, to occur within 60 days after discharge.
- The facility must have procedures in place to provide ongoing blood clot risk assessment for patients who are at high risk of developing blood clots, are pregnant, or are being treated for cancer.

Section 4 amends s. 400.211, F.S., to require that a nursing home's in-service training for certified nursing assistants (CNA) must include recognizing signs and symptoms of a blood clot, pulmonary embolism, or DVT and techniques for providing emergency response. The bill requires that the identification of signs and symptoms of a blood clot and how to assist with a response protocol must be included in the required training a CNA must have in order for a registered nurse to delegate duties to him or her.

Sections 5 and 6 amend ss. 429.41 and 429.52, F.S., respectively, to require rules regulating assisted living facilities (ALF) to include standards for the identification of residents who are at risk for developing blood clots and the treating facility's response protocols to help ensure access to timely treatment, and to require core training for ALF administrators to include identification of and responding to residents at high risk of developing blood clots and pulmonary embolisms.

The bill takes effect July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Article I, Sectio 24(c), of the Florida Constitution requires that any law enacting a new public records exemption contain "only exemptions from [public records and meetings requirements], and shall relate to one subject." Additionally, any law enacting a new public records exemption "shall state with specificity the public necessity justifying the exemption."

Section 2 creates a new public records exemption for records held in the blood clot and pulmonary embolism registry. However, this public records exemption is created within a bill that contains other items and does not relate only to that public records exemption. Additionally, the bill does not specifically state the public necessity for the public records exemption. As such, it is possible that the public records exemption created by the bill may be found to be unconstitutionally enacted, should the bill be enacted.

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 890 may have an indeterminate, negative fiscal impact on facilities licensed under ch. 395, F.S., or ch. 408, F.S., which are required under the bill to report specified information to the blood clot and pulmonary embolism registry created by the bill and adopt new training, policies, protocols, or procedures.

C. Government Sector Impact:

According to the Department of Health (DOH), the bill requires additional staff and data infrastructure resources to include blood clot and pulmonary embolism data into a statewide registry. The cost of such resources is estimated at $2,000,000. The DOH will also incur nonrecurring costs for rulemaking, which can be absorbed within existing resources.[8]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 2 creates the blood clot and pulmonary embolism registry (registry)within the Department of Health (DOH). The bill requires that all facilities licensed with the Agency for Health Care Administration (AHCA) under ch. 408, F.S., provide specified information to the DOH. However, the bill only exempts hospitals from liability for providing such information. It may be advisable to extend liability protection to all facility types that are required to provide information under the bill. Additionally, it is unclear how some facilities licensed under ch. 408, F.S., such as nurse registries and home medical equipment providers, would be able to comply with the requirement to provide the specified information. The bill allows the DOH, by rule, to classify and exempt certain facilities from the bill's reporting requirements, but it is unclear whether this rulemaking authority would be sufficient to allow the DOH to exempt other types of facilities not listed in the bill.

Section 2 specifies that any funds appropriated for the implementation of the registry must be used for "establishing, administering, compiling, processing, and providing biometric and statistical analyses to the reporting facilities." Given the large quantity and the multiple types of facilities required to report, it is unclear whether such reporting would be practical.

Section 3 requires that certain hospitals and ambulatory surgical centers (ASC) provide specified training and create specified policies, protocols, and procedures related to blood clots, pulmonary embolisms, and deep vein thrombosis (DVT). However, the bill does not specify the time frame in which such training, policies, protocols, and procedures must be adopted. It may be advisable to allow hospitals and ASCs a specific amount of time to put such training, policies, protocols, and procedures in place prior to requiring them.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 385.102, 400.211, 429.41, and 429.52.

This bill creates the following sections of the Florida Statutes: 385.213 and 395.3042.

[8] Department of Health, 2025 Agency Legislative Bill Analysis, HB 1421 (April 2, 2025) (on file with the Senate Appropriations Committee on Health and Human Services).

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.

185632

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. This act may be cited as the "Emily Adkins Family Protection Act."

Section 2. Subsection (1) of section 385.102, Florida Statutes, is amended to read:

385.102 Legislative intent.—It is the finding of the Legislature that:

185632

(1) Chronic diseases exist in high proportions among the people of this state. These chronic diseases include, but are not limited to, heart disease, hypertension, diabetes, renal disease, chronic obstructive pulmonary disease, cancer, chronic critical illness, and genetic predisposition for developing venous thromboembolisms ~~chronic obstructive lung disease~~. These diseases are often interrelated, and they directly and indirectly account for a high rate of death and illness.

Section 3. Subsection (5) is added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

(5) Each hospital with an emergency department and each ambulatory surgical center must:

(a) Develop and implement policies and procedures for the rendering of appropriate medical attention for persons at risk of forming venous thromboembolisms which reflect evidence-based best practices relating to, at a minimum:

1. Assessing patients for risk of venous thromboembolism using a nationally recognized risk assessment tool.

2. Treatment options for a patient diagnosed with venous thromboembolism.

(b) Train all nonphysician personnel at least annually on the policies and procedures developed under this subsection. For purposes of this subsection, "nonphysician personnel" means all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners.

Section 4. Section 395.3042, Florida Statutes, is created to read:

185632

395.3042 Statewide venous thromboembolism registry.—

(1)(a) The agency shall contract with a private entity, that meets all of the conditions of paragraph (b), to establish and maintain, at no cost to the state, a statewide venous thromboembolism registry to ensure that the performance measures required to be submitted under subsection (2) are maintained and available for use to improve or modify the venous thromboembolism care system, ensure compliance with nationally recognized guidelines, and monitor venous thromboembolism patient outcomes.

(b) The private entity must:

1. Be a not-for-profit corporation qualified as tax-exempt under s. 501(c)(3) of the Internal Revenue Code.

2. Have existed for at least 15 consecutive years with a mission of advancing the prevention, early diagnosis, and successful treatment of blood clots.

3. Have experience operating a medical registry with at least 25,000 participants.

4. Have experience in providing continuing education on venous thromboembolism to medical professionals.

5. Have sponsored a public health education campaign on venous thromboembolism.

6. Be affiliated with a medical and scientific advisory board.

(2) Beginning July 1, 2026, each hospital with an emergency department and each ambulatory surgical center shall regularly report to the statewide venous thromboembolism registry information containing nationally recognized venous thromboembolism measures and data on the incidence and

185632

prevalence of venous thromboembolisms. Such data must include the following information:

(a) The number of venous thromboembolisms identified and diagnosed.

(b) The age of the patient.

(c) The zip code of the patient.

(d) The sex of the patient.

(e) Whether the patient is a resident of a licensed nursing home or assisted living facility.

(f) Whether the venous thromboembolism was fatal.

(g) How the diagnosis was made, such as by using imaging modalities.

(h) The treatment that was recommended for the venous thromboembolism.

(3) The agency shall require the contracted private entity to use a nationally recognized platform to collect data from each hospital with an emergency department and each ambulatory surgical center on the performance measures required under subsection (2). The contracted private entity shall provide regular reports to the agency on the data collected.

(4) By March 1, 2026, the agency must submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a detailed report on the incidence of venous thromboembolism using inpatient, outpatient, and ambulatory surgical center data for services provided between July 1, 2024, and July 1, 2025. The report shall provide analyses of all of the following:

(a) Age category, initial primary diagnosis and procedure, and secondary diagnoses, readmission rates for inpatients,

185632

admission rates for venous thromboembolism for which the patient had an ambulatory surgery procedure, and emergency department visits for venous thromboembolism linked to any previous admission.

(b) Whether the venous thromboembolism was present upon admission.

(c) The incidence of venous thromboembolism procedures reported on the agency's Florida Health Finder website.

(d) The principal payor, the sex of the patient, and the patient's discharge status.

(5) The contracted private entity operating the registry may only use or publish information from the registry for the purposes of advancing medical research or medical education in the interest of reducing morbidity or mortality.

Section 5. Subsection (4) and paragraph (a) of subsection (5) of section 400.211, Florida Statutes, are amended to read:

400.211 Persons employed as nursing assistants; certification requirement; qualified medication aide designation and requirements.—

(4) When employed by a nursing home facility for a 12-month period or longer, a nursing assistant, to maintain certification, shall submit to a performance review every 12 months and must receive regular inservice education based on the outcome of such reviews. The inservice training must:

(a) Be sufficient to ensure the continuing competence of nursing assistants and must meet the standard specified in s. 464.203(7);

(b) Include, at a minimum:

1. Techniques for assisting with eating and proper feeding;

185632

2. Principles of adequate nutrition and hydration;

3. Techniques for assisting and responding to the cognitively impaired resident or the resident with difficult behaviors;

4. Techniques for caring for the resident at the end-of-life; ~~and~~

5. Recognizing changes that place a resident at risk for pressure ulcers and falls; and

6. Recognizing signs and symptoms of venous thromboembolism and techniques for providing an emergency response; and

(c) Address areas of weakness as determined in nursing assistant performance reviews and may address the special needs of residents as determined by the nursing home facility staff.

Costs associated with this training may not be reimbursed from additional Medicaid funding through interim rate adjustments.

(5) A nursing home, in accordance with chapter 464 and rules adopted pursuant to this section, may authorize a registered nurse to delegate tasks, including medication administration, to a certified nursing assistant who meets the requirements of this subsection.

(a) In addition to the initial 6-hour training course and determination of competency required under s. 464.2035, to be eligible to administer medication to a resident of a nursing home facility, a certified nursing assistant must:

1. Hold a clear and active certification from the Department of Health for a minimum of 1 year immediately preceding the delegation;

2. Complete an additional 34-hour training course approved

185632

by the Board of Nursing in medication administration and associated tasks, including, but not limited to, blood glucose level checks, dialing oxygen flow meters to prescribed settings, ~~and~~ assisting with continuous positive airway pressure devices, and identification of signs and symptoms of venous thromboembolism and how to assist with a response protocol; and

3. Demonstrate clinical competency by successfully completing a supervised clinical practice in medication administration and associated tasks conducted in the facility.

Section 6. Paragraph (g) of subsection (1) of section 429.41, Florida Statutes, is amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also promote a safe and sanitary environment that is residential and noninstitutional in design or nature and may allow for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. The agency, in consultation with the Department of Children and Families and the Department of Health, shall adopt rules to administer this part, which must

185632

include reasonable and fair minimum standards in relation to:

(g) The care of residents provided by the facility, which must include:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The assistance in making arrangements for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication stored within the facility and as needed by residents;

6. The dietary needs of residents;

7. Resident records; ~~and~~

8. Internal risk management and quality assurance; and

9. Identification of residents who are at risk for developing venous thromboembolism and the treating facility's response protocols to help ensure access to timely treatment.

Section 7. Paragraph (h) is added to subsection (3) of section 429.52, Florida Statutes, to read:

429.52 Staff training and educational requirements.—

(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics:

(h) Identification of and responding to residents at high risk of developing venous thromboembolism.

185632

Section 8. This act shall take effect July 1, 2025.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to improving screening for and treatment of blood clots; providing a short title; amending s. 385.102, F.S.; revising legislative findings under the Chronic Diseases Act; amending s. 395.1012, F.S.; requiring hospitals with emergency departments and ambulatory surgical centers to develop and implement policies and procedures and conduct training for the rendering of appropriate medical attention for persons at risk of forming venous thromboembolisms; creating s. 395.3042, F.S.; requiring the Agency for Health Care Administration to contract with a private entity to establish a statewide venous thromboembolism registry at no cost to the state; providing requirements for the private entity; requiring hospitals with an emergency department and ambulatory surgical centers, beginning on a date certain, to regularly report certain information to the statewide venous thromboembolism registry; requiring the agency to require the private entity to use a nationally recognized platform to collect certain data; requiring the private entity to provide regular reports to the agency on such data;

185632

requiring the agency, by a date certain, to provide to the Governor and the Legislature a specified report; providing requirements for such report; providing applicability; amending s. 400.211, F.S.; revising requirements for certain annual inservice training for certified nursing assistants employed by nursing home facilities; revising training requirements for certain certified nursing assistants who may be delegated tasks in nursing home facilities; amending s. 429.41, F.S.; revising minimum standards for the care of residents in assisted living facilities; amending s. 429.52, F.S.; revising requirements for the core competency test for administrators of assisted living facilities; providing an effective date.

By Senator Yarborough

4-01449-25 2025890__

A bill to be entitled

An act relating to improving screening for and treatment of blood clots; amending s. 385.102, F.S.; revising legislative findings under the Chronic Diseases Act; creating s. 385.213, F.S.; requiring the Department of Health to establish, or contract to establish, a statewide registry for a specified purpose; requiring certain licensed facilities to report specified information to the department for inclusion in the registry; specifying limitations on the use and publication of information from the registry; providing that certain personal identifying information is confidential and exempt from public records requirements, with exceptions; specifying requirements for the use of certain appropriated funds; authorizing the department, by rule, to classify facilities for purposes of certain reporting requirements; requiring the department to exempt certain facilities from certain reporting requirements; providing applicability; creating s. 395.3042, F.S.; requiring certain licensed facilities to arrange for the rendering of appropriate medical attention for persons at risk for certain conditions; specifying requirements for the manner in which such facilities must provide such medical attention, including admission, training, and practice policies; amending s. 400.211, F.S.; revising requirements for certain annual inservice training for certified nursing assistants employed by nursing home

4-01449-25 2025890__

facilities; revising training requirements for certain certified nursing assistants who may be delegated tasks in nursing home facilities; amending s. 429.41, F.S.; revising minimum standards for the care of residents in assisted living facilities; amending s. 429.52, F.S.; revising requirements for the core competency test for administrators of assisted living facilities; providing an effective date.

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

Section 1. Subsection (1) of section 385.102, Florida Statutes, is amended to read:

385.102 Legislative intent.—It is the finding of the Legislature that:

(1) Chronic diseases exist in high proportions among the people of this state. These chronic diseases include, but are not limited to, heart disease, hypertension, diabetes, renal disease, chronic obstructive pulmonary disease, cancer, chronic critical illness, and genetic predisposition for developing blood clots and pulmonary embolisms ~~chronic obstructive lung disease~~. These diseases are often interrelated, and they directly and indirectly account for a high rate of death and illness.

Section 2. Section 385.213, Florida Statutes, is created to read:

385.213 Blood clot and pulmonary embolism registry.—

(1) The Department of Health shall establish, or contract with a recognized medical organization in this state and its

affiliated institutions to establish, a statewide registry to ensure blood clot and pulmonary embolism reports required under this section are maintained and available for use in the course of research for the purpose of reducing morbidity and mortality, and liability of any kind or character for damages or other relief may not arise or be enforced against any hospital by reason of having provided such information or material to the department for inclusion in the registry.

(2) Each facility licensed under chapter 395 or chapter 408 shall report to the department for inclusion in the registry all of the following information, and as further specified by department rule, for each instance of a blood clot, pulmonary embolism, or deep vein thrombosis identified in a patient:

(a) The number of blood clots, pulmonary embolisms, and deep vein thromboses identified and diagnosed.

(b) The age of the patient.

(c) The zip code of the patient.

(d) The sex of the patient.

(e) Whether the patient is a resident of a licensed nursing home or assisted living facility.

(f) Whether the blood clot, pulmonary embolism, or deep vein thrombosis was fatal.

(g) How the diagnosis was made, such as by using imaging modalities.

(h) The treatment that was recommended for the blood clot, pulmonary embolism, or deep vein thrombosis, as applicable.

(3) The department or contractor operating the registry may use or publish information from the registry only for the purpose of advancing medical research or medical education in

the interest of reducing morbidity or mortality, except that a summary of such entries without any personal identifying information may be released for general publication. Information which discloses or could lead to the disclosure of personal identifying information of any person whose condition or treatment has been reported and studied is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution as specified in s. 119.0712(1), except that:

(a) Such information may be released with the express written consent of the person or his or her legally authorized representative;

(b) The department or the contractor may contact individuals for the purpose of epidemiologic investigation and monitoring, provided such information that is confidential under this section is not further disclosed; and

(c) The department may exchange data that includes personal identifying information with any other governmental agency or the contractor for the purpose of medical or scientific research, provided such governmental agency or contractor does not further disclose information that is confidential and exempt.

(4) Funds appropriated for implementation of this section must be used for establishing, administering, compiling, processing, and providing biometric and statistical analyses to the reporting facilities. Funds may also be used to ensure the quality and accuracy of the information reported and to provide management information to the reporting facilities.

(5) The department may, by rule, classify facilities for

purposes of reports made to the registry and specify the content and frequency of the reports. In classifying facilities, the department must exempt certain facilities from reporting blood clot and pulmonary embolism information that was previously reported to the department or retrieved from existing state reports made to the department or the Agency for Health Care Administration.

(6) This section does not apply to any facility whose primary function is to provide psychiatric care to its patients.

Section 3. Section 395.3042, Florida Statutes, is created to read:

395.3042 Screening for blood clots, pulmonary embolisms, and deep vein thrombosis in licensed facilities.—Any licensed facility that provides emergency room services, orthopedic services, pregnancy services, or cancer treatment shall arrange for the rendering of appropriate medical attention for persons at risk of blood clots, pulmonary embolisms, or deep vein thrombosis in the following manner:

(1) Upon admission to such a facility, a patient must be assessed for risk of blood clots, pulmonary embolisms, and deep vein thrombosis using a nationally recognized risk assessment tool.

(2) The training of all staff in the facility must include continuing education annually on how to recognize a blood clot, pulmonary embolism, or deep vein thrombosis.

(3) The facility shall have established protocols for staff to ensure that patients diagnosed with a life-threatening blood clot, pulmonary embolism, or deep vein thrombosis are assessed for various treatment options.

(4) The facility shall have an established policy in place requiring a follow-up for all orthopedic patients who have undergone lower extremity or pelvic surgery, to occur within 60 days after discharge.

(5) The facility shall have procedures in place to provide ongoing blood clot risk assessment for patients who are at high risk of developing blood clots, are pregnant, or are being treated for cancer.

Section 4. Subsection (4) and paragraph (a) of subsection (5) of section 400.211, Florida Statutes, are amended to read:

400.211 Persons employed as nursing assistants; certification requirement; qualified medication aide designation and requirements.—

(4) When employed by a nursing home facility for a 12-month period or longer, a nursing assistant, to maintain certification, shall submit to a performance review every 12 months and must receive regular inservice education based on the outcome of such reviews. The inservice training must:

(a) Be sufficient to ensure the continuing competence of nursing assistants and must meet the standard specified in s. 464.203(7);

(b) Include, at a minimum:

1. Techniques for assisting with eating and proper feeding;

2. Principles of adequate nutrition and hydration;

3. Techniques for assisting and responding to the cognitively impaired resident or the resident with difficult behaviors;

4. Techniques for caring for the resident at the end-of-life; ~~and~~

5. Recognizing changes that place a resident at risk for pressure ulcers and falls; and

6. Recognizing signs and symptoms of a blood clot, pulmonary embolism, or deep vein thrombosis and techniques for providing an emergency response; and

(c) Address areas of weakness as determined in nursing assistant performance reviews and may address the special needs of residents as determined by the nursing home facility staff.

Costs associated with this training may not be reimbursed from additional Medicaid funding through interim rate adjustments.

(5) A nursing home, in accordance with chapter 464 and rules adopted pursuant to this section, may authorize a registered nurse to delegate tasks, including medication administration, to a certified nursing assistant who meets the requirements of this subsection.

(a) In addition to the initial 6-hour training course and determination of competency required under s. 464.2035, to be eligible to administer medication to a resident of a nursing home facility, a certified nursing assistant must:

1. Hold a clear and active certification from the Department of Health for a minimum of 1 year immediately preceding the delegation;

2. Complete an additional 34-hour training course approved by the Board of Nursing in medication administration and associated tasks, including, but not limited to, blood glucose level checks, dialing oxygen flow meters to prescribed settings, ~~and~~ assisting with continuous positive airway pressure devices, and identification of signs and symptoms of a blood clot and how

to assist with a response protocol; and

3. Demonstrate clinical competency by successfully completing a supervised clinical practice in medication administration and associated tasks conducted in the facility.

Section 5. Paragraph (g) of subsection (1) of section 429.41, Florida Statutes, is amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also promote a safe and sanitary environment that is residential and noninstitutional in design or nature and may allow for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. The agency, in consultation with the Department of Children and Families and the Department of Health, shall adopt rules to administer this part, which must include reasonable and fair minimum standards in relation to:

(g) The care of residents provided by the facility, which must include:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The assistance in making arrangements for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication stored within the facility and as needed by residents;

6. The dietary needs of residents;

7. Resident records; ~~and~~

8. Internal risk management and quality assurance; and

9. Identification of residents who are at risk for developing blood clots, and the treating facility's response protocols to help ensure access to timely treatment.

Section 6. Paragraph (h) is added to subsection (3) of section 429.52, Florida Statutes, to read:

429.52 Staff training and educational requirements.—

(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics:

(h) Identification of and responding to residents at high risk of developing blood clots and pulmonary embolisms.

Section 7. This act shall take effect July 1, 2025.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	CS/SB 954
INTRODUCER:	Community Affairs Committee and Senator Gruters
SUBJECT:	Certified Recovery Residences
DATE:	April 14, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hackett	Fleming	CA	**Fav/CS**
2.	Sneed	McKnight	AHS	**Pre-meeting**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 954 relates to recovery residences certified before July 1, 2025. Specifically, the bill:

- Limits the ability of local governments to bar those certified recovery residences from operating in multifamily structures;
- Requires local governments to treat those recovery residences as a non-transient residential use of land under local zoning ordinances; and
- Prohibits local governments from regulating the duration or frequency of use of those certified recovery residences in a multifamily structure.

For certain Level IV certified recovery residences, the bill also eliminates staffing requirements when patients are not present, and increases the number of residents that a recovery residence administrator can oversee from 150 to 500 if the operator maintains a minimum 1:6 personnel-to-resident ratio when residents are present.

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

The bill takes effect July 1, 2025.

II. Present Situation:

Substance abuse is the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[1] According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), a diagnosis of substance use disorder (SUD) is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[2] SUD occurs when an individual chronically uses alcohol or drugs, resulting in significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[3] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[4] Imaging studies of brains belonging to persons with SUD reveal physical changes in areas of the brain critical to judgment, decision making, learning and memory, and behavior control.[5]

In 2021, approximately 46.3 million people aged 12 or older had a SUD related to corresponding use of alcohol or illicit drugs within the previous year.[6] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, opioids, hallucinogens, and stimulants. Provisional data from the CDC's National Center for Health Statistics indicate there were an estimated 107,622 drug overdose deaths in the United States during 2021 (the last year for which there is complete data), an increase of nearly 15% from the 93,655 deaths estimated in 2020.[7]

Substance Abuse Treatment in Florida

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse. The laws resulted in separate funding streams and requirements for alcoholism and drug abuse. In response to the laws, the Florida Legislature enacted chs. 396 and 397, F.S., relating to alcohol and drug abuse, respectively.[8] Each of these laws governed different aspects of addiction, and thus had different rules promulgated by the state to fully implement the respective pieces of legislation.[9]

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[1] The World Health Organization, *Mental Health and Substance Abuse*, available at https://www.who.int/westernpacific/about/how-we-work/programmes/mental-health-and-substance-abuse; (last visited March 28, 2025); the National Institute on Drug Abuse (NIDA), *The Science of Drug Use and Addiction: The Basics*, available at https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics (last visited March 28, 2025).
[2] The National Association of Addiction Treatment Providers, *Substance Use Disorder*, available at https://www.naatp.org/resources/clinical/substance-use-disorder (last visited March 28, 2025).
[3] Substance Abuse and Mental Health Services Administration (SAMHSA), *Substance Use Disorders*, http://www.samhsa.gov/disorders/substance-use (last visited March 28, 2025).
[4] The NIDA, *Drugs, Brains, and Behavior: The Science of Addiction*, available at https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited March 28, 2025).
[5] *Id*.
[6] SAMHSA, *Highlights for the 2021 National Survey on Drug Use and Health*, p. 2, available at https://www.samhsa.gov/data/sites/default/files/2022-12/2021NSDUHFFRHighlights092722.pdf (last visited March 28, 2025).
[7] The Center for Disease Control and Prevention, National Center for Health Statistics, *U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 – But Are Still Up 15%*, available at https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm (last visited March 28, 2025).
[8] *Id*.
[9] *Id*.

However, because persons with substance abuse issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address Florida's substance abuse problem.[10] In 1993, legislation was adopted to combine ch. 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).[11]

The Marchman Act encourages individuals to seek services on a voluntary basis within the existing financial and space capacities of a service provider.[12] However, denial of addiction is a prevalent symptom of SUD, creating a barrier to timely intervention and effective treatment.[13] As a result, treatment typically must stem from a third party providing the intervention needed for SUD treatment.[14]

The Department of Children and Families (DCF) administers a statewide system of safety net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery for children and adults who are otherwise unable to obtain these services. Services are provided based upon state and federally established priority populations.[15] The DCF provides treatment for SUD through a community-based provider system offering detoxification, treatment, and recovery support for individuals affected by substance misuse, abuse, or dependence.[16]

- **Detoxification Services:** Detoxification services use medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.[17]
- **Treatment Services:** Treatment services[18] include a wide array of assessment, counseling, case management, and support that are designed to help individuals who have lost their ability to control their substance use on their own and require formal, structured intervention and support.[19]
- **Recovery Support:** Recovery support services, including transitional housing, life skills training, parenting skills, and peer-based individual and group counseling are offered during

[10] The Center for Disease Control and Prevention, National Center for Health Statistics, *U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 – But Are Still Up 15%*, available at https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm (last visited March 28, 2025).
[11] Chapter 93-39, s. 2, L.O.F., which codified current ch. 397, F.S.
[12] *See* s. 397.601(1) and (2), F.S. An individual who wishes to enter treatment may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.
[13] Darran Duchene and Patrick Lane, *Fundamentals of the Marchman Act*, Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Programs, available at http://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited March 28, 2025) (hereinafter cited as "Fundamentals of the Marchman Act").
[14] *Id*.
[15] *See* chs. 394 and 397, F.S.
[16] The Department of Children and Families, *Treatment for Substance Abuse*, available at https://www.myflfamilies.com/services/samh/treatment (last visited March 28, 2025).
[17] *Id*.
[18] *Id*. Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child-protective system, employment, increased earnings, and better health.
[19] *Id*.

and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.[20]

Day or Night Treatment with Community Housing

The DCF licenses "Day or Night Treatment" facilities both with and without community housing components. Day or night treatment programs provide substance use treatment as a service in a nonresidential environment, with a structured schedule of treatment and rehabilitative services.[21] Day or night treatment programs with community housing are intended for individuals who can benefit from living independently in peer community housing while participating in treatment services for a minimum of 5 hours a day or 25 hours per week.[22]

Day or night treatment with community housing is appropriate for individuals who do not require structured, 24 hours a day, 7 days a week residential treatment.[23] The housing must be provided and managed by the licensed service provider, including room and board and any ancillary services such as supervision, transportation, and meals. Activities for day or night treatment with community housing programs emphasize rehabilitation and treatment services using multidisciplinary teams to provide integration of therapeutic and family services.[24] This component allows individuals to live in a supportive, community housing location while participating in treatment. Treatment must not take place in the housing where the individuals live, and the housing must be utilized solely for the purpose of assisting individuals in making a transition to independent living.[25] Individuals who are considered appropriate for this level of care:

- Would not have active suicidal or homicidal ideation or present a danger to self or others;
- Are able to demonstrate motivation to work toward independence;
- Are able to demonstrate a willingness to live in supportive community housing;
- Are able to demonstrate commitment to comply with rules established by the provider;
- Are not in need of detoxification or residential treatment; and
- Typically need ancillary services such as transportation, assistance with shopping, or assistance with medical referrals and may need to attend and participate in certain social and recovery oriented activities in addition to other required clinical services.[26]

Services provided by such programs may include:

- Individual counseling;
- Group counseling;
- Counseling with families or support system;
- Substance-related and recovery-focused education, such as strategies for avoiding substance use or relapse, information regarding health problems related to substance use, motivational enhancement, and strategies for achieving a substance-free lifestyle;

[20] The Department of Children and Families, *Treatment for Substance Abuse*, available at https://www.myflfamilies.com/services/samh/treatment (last visited March 28, 2025).
[21] Section 397.311(26)(a)2., F.S.
[22] Section 397.311(26)(a)3., F.S.
[23] Rule 65D-30.0081(1), F.A.C.
[24] *Id*.
[25] *Id*.
[26] *Id*.

- Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery management, decision-making, relationship skills, symptom management, and food purchase and preparation;
- Expressive therapies, such as recreation therapy, art therapy, music therapy, or dance (movement) therapy to provide the individual with alternative means of self-expression and problem resolution;
- Training or provision of information regarding health and medical issues;
- Employment or educational support services to assist individuals in becoming financially independent;
- Nutrition education; and
- Mental health services for the purpose of:
  - Managing individuals with disorders who are stabilized,
  - Evaluating individuals' needs for in-depth mental health assessment,
  - Training individuals to manage symptoms; and
  - If the provider is not staffed to address primary mental health problems that may arise during treatment, the provider shall initiate a timely referral to an appropriate provider for mental health crises or for the emergence of a primary mental health disorder in accordance with the provider's policies and procedures.[27]

Each enrolled individual must receive a minimum of 25 hours of service per week, including:
- Counseling;
- Group counseling; or
- Counseling with families or support systems.[28]

Each provider is required to arrange for or provide transportation services, if needed and as appropriate, to clients who reside in community housing.[29] Each provider must have an awake, paid employee on the premises at all times at the treatment location when one or more individuals are present.[30] For adults, the provider must have a paid employee on call during the time when individuals are at the community housing location.[31] In addition, the provider must have an awake, paid employee at the community housing location at all times if individuals under the age of 18 are present.[32] No primary counselor may have a caseload that exceeds 15 individuals.[33] For individuals in treatment who are granted privilege to self-administer their own medications, provider staff are not required to be present for the self-administration.[34]

Recovery Residences

Recovery residences (also known as "sober homes" or "sober living homes") are alcohol- and drug-free living environments for individuals in recovery who are attempting to maintain

[27] Rule 65D-30.0081(2), F.A.C.
[28] Rule 65D-30.0081(4), F.A.C.
[29] Rule 65D-30.0081(5), F.A.C.
[30] Rule 65D-30.0081(6), F.A.C.
[31] *Id*.
[32] *Id*.
[33] Rule 65D-30.0081(7), F.A.C.
[34] Rule 65D-30.0081(8), F.A.C.

abstinence from alcohol and drugs.[35] These residences offer no formal treatment and are, in some cases, self-funded through resident fees.

A recovery residence is defined as "a residential dwelling unit, the community housing component of a licensed day or night treatment facility with community housing, or other form of group housing, which is offered or advertised through any means, including oral, written, electronic, or printed means, by any person or entity as a residence that provides a peer-supported, alcohol-free, and drug-free living environment."[36]

Staffing Requirements for Certified Recovery Residences

A certified recovery residence administrator (CRAA) may actively manage up to 50 residents at any given time, though may manage up to 100 residents if written justification is provided to, and approved by, the credentialing entity as to how the administrator is able to effectively and appropriately respond to the needs of the residents, maintain residence standards, and meet the residence certification requirements.[37] CRRAs at certain Level IV certified recovery residences (those operating as community housing as defined in s. 397.311(9), F.S., which residence is actively managed by a certified recovery residence administrator approved for 100 residents under this section and is wholly owned or controlled by a licensed service provider) are allowed to actively manage up to 150 residents provided certain conditions are met:

- Maintains a personnel-to-patient ratio of 1 to 8;
- Maintains onsite supervision at the residence 24 hours a day, 7 days a week; and
- Has a personnel-to-resident ratio of 1 to 10.[38]

Recovery Residence Levels of Support

Section 397.311(5), F.S., establishes a four level-classification of certified recovery residences, including:

- Level I—houses individuals in recovery who have completed treatment, with a minimum of 9 months of sobriety. A Level I certified recovery residence is democratically run by the members who reside in the home.
- Level II—encompasses the traditional perspectives of sober living homes. There is oversight from a house manager who has experience with living in recovery. Residents are expected to follow rules outlined in a resident handbook provided by the certified recovery residence administrator. Residents must pay dues, if applicable, and work toward achieving realistic and defined milestones within a chosen recovery path.
- Level III—offers higher supervision by staff with formal training to ensure resident accountability. Such residences are staffed 24 hours a day, 7 days a week, and offer residents peer-support services, which may include, but are not limited to, life skill mentoring, recovery planning, and meal preparation. Clinical services may not be performed at the residence. Such residences are most appropriate for persons who require a more structured environment during early recovery from addiction.

[35] SAMSHA, *Recovery Housing: Best Practices and Suggested Guidelines*, p. 2, available at https://www.samhsa.gov/sites/default/files/housing-best-practices-100819.pdf (last visited March 28, 2025).
[36] Section 397.311(38), F.S.
[37] Section 397.4871(6)(b), F.S.
[38] Section 397.4871(8)(b) and (c), F.S.

- Level IV—is a residence offered, referred to, or provided by, a licensed service provider to its patients who are required to reside at the residence while receiving intensive outpatient and higher levels of outpatient care. Such residences are staffed 24 hours a day and combine outpatient licensable services with recovery residential living. Residents are required to follow a treatment plan and attend group and individual sessions, in addition to developing a recovery plan within the social model of living in a sober lifestyle. No clinical services are provided at the residence and all licensable services are provided offsite.

Voluntary Certification of Recovery Residences and Administrators in Florida

Florida has a voluntary certification programs for recovery residences and recovery residence administrators, conducted by private credentialing entities.[39] Under the voluntary certification program, the DCF has approved two credentialing entities to design the certification programs and issue certificates: the Florida Association of Recovery Residences (FARR) certifies recovery residences and the Florida Certification Board (FCB) certifies recovery residence administrators.[40] Under the voluntary certification program, recovery residences are classified into four levels of care, with Level IV being the most intense level.[41]

Credentialing entities must require prospective recovery residences to submit the following documents with a completed application and fee:

- A policy and procedures manual containing:
  - Job descriptions for all staff positions;
  - Drug-testing procedures and requirements;
  - A prohibition on the premises against alcohol, illegal drugs, and the use of prescribed medications by an individual other than the individual for whom the medication is prescribed;
  - Policies to support a resident's recovery efforts; and
  - A good neighbor policy to address neighborhood concerns and complaints.
- Rules for residents;
- Copies of all forms provided to residents;
- Intake procedures;
- Sexual predator and sexual offender registry compliance policy;
- Relapse policy;
- Fee schedule;
- Refund policy;
- Eviction procedures and policy;
- Code of ethics;
- Proof of insurance;
- Proof of background screening; and
- Proof of satisfactory fire, safety, and health inspections.[42]

[39] Sections 397.487 through 397.4872, F.S.
[40] The Department of Children and Families, *Recovery Residence Administrators and Recovery Residences*, available at https://www.myflfamilies.com/services/samh/recovery-residence-administrators-and-recovery-residences (last visited March 28, 2025).
[41] Section 397.311, F.S., and sections 397.487 through 397.4873, F.S.
[42] Section 397.487(3), F.S.

Patient Referrals

While certification is voluntary, Florida law incentivizes certification. Since 2016, Florida has prohibited licensed substance abuse service providers from referring patients to a recovery residence unless the recovery residence holds a valid certificate of compliance and is actively managed by a certified recovery residence administrator (CRRA).[43] There are certain exceptions that allow referrals to or from uncertified recovery residences, including any of the following:

- A licensed service provider under contract with a behavioral health managing entity.
- Referrals by a recovery residence to a licensed service provider when the recovery residence or its owners, directors, operators, or employees do not benefit, directly or indirectly, from the referral.
- Referrals made before July 1, 2018, by a licensed service provider to that licensed service provider's wholly owned subsidiary.
- Referrals to, or accepted referrals from, a recovery residence with no direct or indirect financial or other referral relationship with the licensed service provider, and that is democratically operated by its residents pursuant to a charter from an entity recognized or sanctioned by Congress, and where the residence or any resident of the residence does not receive a benefit, directly or indirectly, for the referral.[44]

Service providers are required to record the name and location of each recovery residence that the provider has referred patients to or received referrals from in the DCF Provider Licensure and Designations System.[45] Prospective service providers must also include the names and locations of any recovery residences which they plan to refer patients to, or accept patients from, on their application for licensure.[46]

Residences managed by a certified recovery residence administrator approved for up to 100 residents and wholly owned or controlled by a licensed service provider may accommodate up to 150 residents under certain conditions.[47] These conditions include maintaining a service provider personnel-to-patient ratio of 1 to 8 and providing onsite supervision 24/7 with a personnel-to-resident ratio of 1 to 10. Additionally, administrators overseeing Level IV certified recovery residences with a personnel-to-resident ratio of 1 to 6 are not subject to limitations on the number of residents they may manage.

Zoning and Land Use

The Growth Management Act requires every city and county to create and implement a comprehensive plan to guide future development.[48] All development, both public and private, and all development orders[49] approved by local governments must be consistent with the local

[43] Section 397.4873(1), F.S.
[44] Section 397.4873(2)(a)-(d), F.S.
[45] Section 397.4104(1), F.S.
[46] Section 397.403(1)(j), F.S.
[47] Section 397.4871(8)(c), F.S.
[48] Section 163.3167(2), F.S.
[49] "Development order" means any order granting, denying, or granting with conditions an application for a development permit. See s. 163.3164(15), F.S. "Development permit" includes any building permit, zoning permit, subdivision approval, rezoning, certification, special exception, variance, or any other official action of local government having the effect of permitting the development of land. See s. 163.3164(16), F.S.

government's comprehensive plan unless otherwise provided by law.[50] The Future Land Use Element in a comprehensive plan establishes a range of allowable uses and densities and intensities over large areas, and the specific use and intensities for specific parcels within that range are decided by a more detailed, implementing zoning map.[51]

III. Effect of Proposed Changes:

Section 1 amends s. 397.487, F.S., to preempt local governments such that certified recovery residences are deemed residential use for all local zoning ordinances, no local ordinance may prohibit or regulate recovery residences in a multifamily structure, and the establishment of recovery residences in all districts zoned multifamily residential must be permitted without zoning or land use change. A local government must allow the establishment of a certified recovery residence in all districts zoned multifamily residential and allow a structure originally constructed and permitted for multifamily purposes to be used as a certified recovery residence, allowing up to two residents per bedroom, without obtaining a zoning or a land use change, a special exception, a conditional use approval, a variance, or a comprehensive plan amendment.

The recovery residence in question must either not occupy or fully occupy a community or structure that is governed by a condominium association under ch. 718, F.S. The bill includes exceptions to these requirements, permitting a municipality or a county to deny the establishment of a Level IV certified recovery residence if:

- The proposed use is adjacent to (meaning those properties sharing more than one point of a property line, but not including properties separated by a public road), or on two or more sides of, a parcel zoned for single-family residential use; and
- Is within a single-family residential development with at least 25 contiguous single-family homes.

Section 2 amends s. 397.4871, F.S., to provide that a certified recovery residence administrator for level IV certified recovery residence which maintains a personnel-to-resident ratio of 1 to 6 may manage up to 500 residents. Currently the maximum allowed is 150 residents with a 1 to 8 ratio. The bill also amends the 24/7 onsite supervision requirement to only apply during times when residents are at the residence.

The bill takes effect July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[50] Section 163.3194(3), F.S

[51] Richard Grosso, A Guide to Development Order "Consistency" Challenges Under Florida Statutes Section 163.3215, 34 J. Envtl. L. & Litig. 129, 154 (2019) citing Brevard Cty. v. Snyder, 627 So. 2d 469, 475 (Fla. 1993).

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The overall effect of the bill may be to simplify the establishment and maintenance of a recovery residence, providing an indeterminate positive impact.

C. Government Sector Impact:

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

VI. Technical Deficiencies:

None.

VII. Related Issues:

The sections related to recovery residences as approved use in residential zoned areas subject to administrative approval fail to detail the nature of that approval and how a local government is required to treat such a proposed action.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 397.487 and 397.4871.

IX. Additional Information:

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

CS by Community Affairs on March 31, 2025:
The committee substitute removes all provisions of the bill except:

- The provisions of section 4 declaring a certified recovery residence is deemed a nontransient residential use of land for the purposes of all local zoning ordinances. The provisions requiring administrative approval and a reduction of parking requirements are removed.
- Section 5, adjusting bed limits by personnel-to-resident ratio. This provision is modified to provide a 500 resident limit.

B. Amendments:

None.

By the Committee on Community Affairs; and Senator Gruters

578-03100-25 2025954c1

A bill to be entitled

An act relating to certified recovery residences; amending s. 397.487, F.S.; providing that certain recovery residences are deemed a nontransient residential use of land for a specified purpose; prohibiting a local law, ordinance, or regulation from prohibiting or regulating a recovery residence in a multifamily structure; requiring a county or a municipality to allow certain certified recovery residences in specified zoned districts without the need to obtain changes in certain zoning or land use; specifying the allowable use of such certified recovery residences; authorizing a municipality or a county to deny the establishment of a certified Level IV recovery residence if the proposed use is adjacent to, or on two or more sides of, a parcel zoned for a specified use and within a certain single-family residential development; defining the term "adjacent to"; providing applicability; amending s. 397.4871, F.S.; providing that the personnel-to-resident ratio for a certified recovery residence must be met only when the residents are at the residence; providing that a certified recovery residence administrator for Level IV certified recovery residences which maintains a specified personnel-to-patient ratio has a limitation on the number of residents it may manage; providing an effective date.

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

578-03100-25 2025954c1

Section 1. Subsection (15) is added to section 397.487, Florida Statutes, to read:

397.487 Voluntary certification of recovery residences.—

(15)(a) A certified recovery residence that does not occupy a community or structure that is governed by a condominium association under chapter 718, or which fully occupies a community or structure that is governed by a condominium association under chapter 718, is deemed a nontransient residential use for purposes of all local zoning ordinances. A local law, ordinance, or regulation may not prohibit certified recovery residences or regulate the duration or frequency of use of a certified recovery residence in a multifamily structure.

(b) A municipality or county shall allow the establishment of a certified recovery residence in all districts zoned multifamily residential and shall allow a structure originally constructed and permitted for multifamily purposes to be used as a certified recovery residence, allowing up to two residents per bedroom, without obtaining a zoning or a land use change, a special exception, a conditional use approval, a variance, or a comprehensive plan amendment for the zoning and densities authorized under this subsection.

(c) A municipality or a county may deny the establishment of a Level IV certified recovery residence if the proposed use is adjacent to, or on two or more sides of, a parcel zoned for single-family residential use and is within a single-family residential development with at least 25 contiguous single-family homes. For the purposes of this paragraph, the term "adjacent to" means those properties sharing more than one point

of a property line, but the term does not include properties separated by a public road.

(d) This subsection applies to certified recovery residence providers that were voluntarily certified by the credentialing entity pursuant to this section on or before July 1, 2025.

Section 2. Paragraph (c) of subsection (8) of section 397.4871, Florida Statutes, is amended to read:

397.4871 Recovery residence administrator certification.—

(8)

(c) Notwithstanding paragraph (b), a Level IV certified recovery residence operating as community housing as defined in s. 397.311(9), which residence is actively managed by a certified recovery residence administrator approved for 100 residents under this section and is wholly owned or controlled by a licensed service provider, may:

1. Actively manage up to 150 residents so long as the licensed service provider maintains a service provider personnel-to-patient ratio of 1 to 8 and maintains onsite supervision at the residence during times when residents are at the residence ~~24 hours a day, 7 days a week,~~ with a personnel-to-resident ratio of 1 to 10.

2. Actively manage up to 500 residents, so long as the licensed service provider maintains a service provider personnel-to-patient ratio of 1 to 8 and maintains onsite supervision at the residence during times when residents are at the residence with a personnel-to-resident ratio of 1 to 6.

A certified recovery residence administrator who has been removed by a certified recovery residence due to termination,

resignation, or any other reason may not continue to actively manage more than 50 residents for another service provider or certified recovery residence without being approved by the credentialing entity.

Section 3. This act shall take effect July 1, 2025.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	CS/SB 1050
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Bradley
SUBJECT:	Services for Individuals with Developmental Disabilities
DATE:	April 14, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rao	Tuszynski	CF	**Fav/CS**
2.	Howard	McKnight	AHS	**Pre-meeting**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1050 expands the Intellectual and Developmental Disabilities (IDD) Pilot Program in three phases, aiming to open voluntary enrollment to all individuals with developmental disabilities enrolled in a Medicaid waiver program by July 1, 2026.

The bill clarifies that the Agency for Health Care Administration (AHCA) is responsible for administering the program, with the Agency for Persons with Disabilities (APD) supporting its implementation.

The bill enhances transparency by requiring the APD to post quarterly reconciliation reports and the iBudget preenrollment list online. It also directs the APD to seek federal approval for the Adult Pathways Home and Community-Based Services Medicaid waiver and participate in transition planning for dependent youth aging out of the child welfare system.

Additionally, the bill creates a statewide family care council to coordinate with local councils and outlines its structure, membership, responsibilities, and reporting requirements.

The bill may have a significant, yet indeterminate, negative fiscal impact on state expenditures. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

II. Present Situation:

The present situation is presented in Section III under the Effect of Proposed Changes.

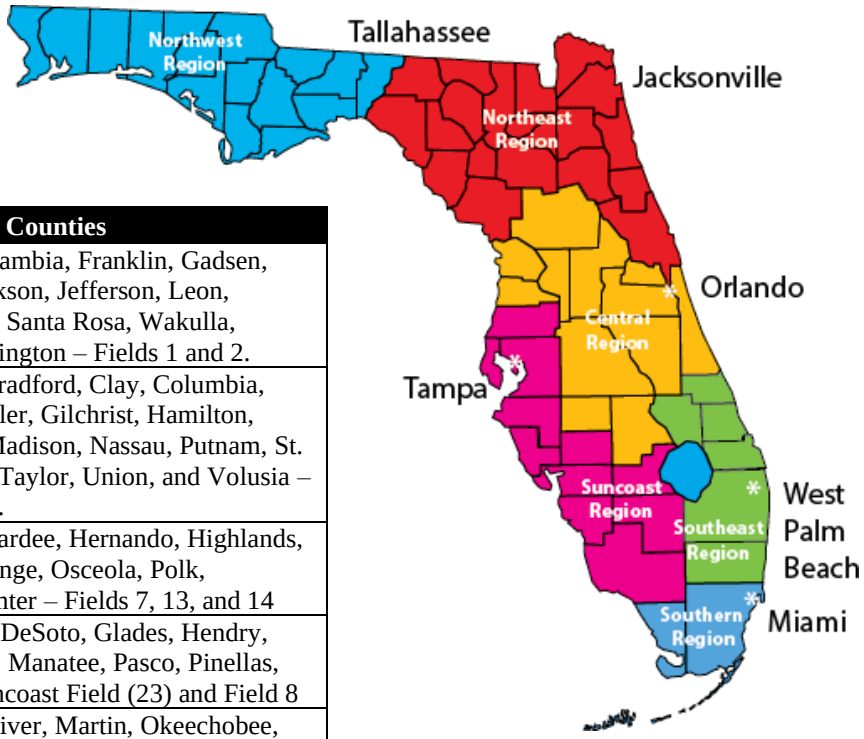
III. Effect of Proposed Changes:

Services for Individuals with Disabilities

Present Situation

Agency for Persons with Disabilities
Chapter 393, F.S., identifies the need to provide community-based services and programs for individuals with developmental disabilities that enable individuals to achieve their greatest potential for independent living while reducing the number of individuals in unnecessary institutional placements.[1]

The Agency for Persons with Disabilities (APD) provides services to individuals with developmental disabilities and manages Medicaid waivers that provide federally approved services for individuals with developmental disabilities.[2] In addition to central headquarters in Tallahassee, the APD operates a total of six regional offices and 14 field offices throughout the state, as detailed below:[3]



Regions	Counties
Northwest	Bay, Calhoun, Escambia, Franklin, Gadsen, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Walton, and Washington – Fields 1 and 2.
Northeast	Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Madison, Nassau, Putnam, St. Johns, Suwannee, Taylor, Union, and Volusia – Fields 3, 4, and 12.
Central	Brevard, Citrus, Hardee, Hernando, Highlands, Lake, Marion, Orange, Osceola, Polk, Seminole, and Sumter – Fields 7, 13, and 14
Suncoast	Charlotte, Collier, DeSoto, Glades, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, and Sarasota – Suncoast Field (23) and Field 8
Southeast	Broward, Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie – Fiels 9 and 10
Southern	Dade and Monroe – Field 11

[1] Section 393.062, F.S.
[2] Section 20.197, F.S.
[3] Agency for Persons with Disabilities, *Regional Offices*, available at: https://apd.myflorida.com/region/ (last visited March 11, 2025).

Individual Budgeting (iBudget) Waiver

Florida has obtained several Medicaid waivers[4] to enable the provision of specified home and community-based services to persons at risk of institutionalization.[5] The intended target populations are older adults, people with intellectual or developmental disabilities, physical disabilities, or mental health and substance use disorders.[6] These services are intended to allow recipients to remain at home or in a home-like setting, and are funded by the Florida Agency for Health Care Administration (AHCA).[7]

The Individual Budgeting Waiver (iBudget) is one of the Home and Community-Based Services federal waivers.[8] The APD administers the iBudget waiver in Florida for individuals with specified developmental disabilities who meet Medicaid eligibility requirements.[9] The iBudget program provides the client with an established budget; with this budget, the client may choose services within a specified service package that best allows them to live in their community.[10]

The APD serves 35,790 individuals through iBudget Florida, contracting with service providers to offer various supports and services to assist individuals to live in their community.[11] Examples of waiver services include residential habilitation, behavioral services, personal supports, adult day care training, employment services, and occupational and physical therapy.[12]

iBudget Preenrollment Categories

Based on the available slots in the iBudget waiver program, applicants may either be placed in the program or placed on a wait list if the demand exceeds available funding. The APD assigns each waitlisted client to a preenrollment category based on their needs. As more funding is available, clients are taken off the preenrollment categories and placed on the program, in descending priority order; meaning, the clients who have the highest needs are enrolled in the program first. The following table displays the number of individuals in the preenrollment categories as of March 18, 2025[13]:

[4] A Medicaid waiver allows a state to waive certain eligibility requirements and cover individuals who may not otherwise be eligible for Medicaid care. *See* Centers for Medicare & Medicaid Services, *State Medicaid Plans and Waivers*, available at: https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/state-medicaid-plans-and-waivers (last visited March 25, 2025).
[5] 59G-13.080, Florida Administrative Code
[6] Medicaid.gov, Home and Community Based Services, available at: https://www.medicaid.gov/medicaid/home-community-based-services/index.html (last visited March 13, 2025).
[7] Rule 59G-13.080(1), F.S. 393.062, F.S.; Section 409.906, F.S.
[8] Florida Agency for Health Care Administration, Florida Medicaid's Covered Services and HCBS Waivers, available at: https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/florida-medicaid-s-covered-services-and-hcbs-waivers (last visited March 13, 2025).
[9] Section 393.0662, F.S.
[10] *Id.*
[11] March 24, 2025 E-mail from Anna Grace Futch, Legislative Affairs Director, the APD (on file with the Senate Committee on Children, Families, and Elder Affairs).
[12] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs First Quarter Fiscal Year 2022-2023*, available at: https://apd.myflorida.com/publications/reports/ (last visited March 14, 2025).
[13] March 24, 2025 E-mail from Anna Grace Futch, Legislative Affairs Director, the APD (on file with the Senate Committee on Children, Families, and Elder Affairs).

iBudget Preenrollment Categories		
Preenrollment Category	**Description**	**Total Number of Clients**
Category 1	Clients in crisis	-
Category 2	Children in the Child Welfare System at the time of permanency or turning 18 years of age	-
Category 3	Intensive Needs	170
Category 4	Caregiver Over Age 60	522
Category 5	Clients transitioning from school	22
Category 6	Clients Age 21 and Over who do not meet the criteria for categories 1, 2, 3, 4, or 5	12,323
Category 7	Clients Age 21 and Younger who do not meet the criteria for categories 1, 2, 3, or 4	7,985
	Grand Total of Clients	**21,022**

Dependent Children and Category Two Preenrollment

Florida's dependency system is charged with protecting children who have been abused, abandoned, or neglected.[14] The Department of Children and Families (DCF) and community-based care lead agencies (CBCs) work with families to address problems endangering children, if possible.[15] If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children.[16] During this time, the DCF strives to achieve permanency for the child before the child's 18th birthday.[17] However, a child will age out of care upon reaching 18 years of age if a permanent placement is not found.[18]

During the year after a child reaches age 16 years, the DCF and CBC lead agency are required to collaborate with the caregiver to assist the child in developing a transition plan.[19] The transition plan must address options for the child to obtain services such as housing, health insurance, education, financial literacy, a driver license, and workforce support.[20] Additionally, the court is required to conduct judicial reviews of children aging out of the child welfare system, to determine if they have obtained appropriate life skills to live independently and ensure the child has information about services they may be eligible to receive after reaching 18 years of age.[21]

Reconciliation Reports

Current law requires the APD, in consultation with the AHCA, to provide a quarterly reconciliation report of all home and community-based services waiver expenditures.[22] These reports compare the funds appropriated to fulfill the waiver with the actual expenditures,

[14] Ch. 39, F.S.
[15] Ch. 39, F.S.
[16] Ch. 39, F.S.
[17] Section 39.621, F.S.
[18] Rule 65C-30.022, Florida Administrative Code
[19] Section 39.6035, F.S.
[20] *Id.*
[21] Section 39.701(3), F.S.
[22] Section 393.0662 (14), F.S.

providing the utilization rate of the waiver services.[23] The APD must submit reconciliation reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than 30 days after the close of each quarter.[24]

Effect of Proposed Changes

Section 1 amends s. 393.0662, F.S., to require the APD to post its quarterly reconciliation reports for the iBudget waiver on its website in a conspicuous location, no later than five days after submitting the reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 2 amends s. 393.065, F.S., to require the APD's online application to allow an applicant to apply for crisis enrollment (Category 1) on the iBudget waiver.

The bill requires the APD to participate in transition planning activities for individuals assigned to preenrollment category 2, which are children aging out of the child welfare system. These activities include, but are not limited to, the following:
- Individualized service coordination;
- Case management support; and
- Ensuring continuity of care pursuant to s. 39.6035, F.S.

The bill removes the requirement that the APD must remove from the preenrollment categories any individual that meets one of the following conditions:
- Cannot be located using the contact information provided to the APD;
- Fails to meet eligibility requirements; or
- Becomes domiciled outside the state.

The bill requires the APD to post the total number of individuals in each iBudget preenrollment category on its website in a conspicuous location. The bill requires the posted numbers to reflect the current status of the preenrollment priority list and be updated at least every five days.

Intellectual and Developmental Disabilities Pilot Program

Present Situation

Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) is the chief health policy and planning entity for Florida.[25] Current law requires the AHCA to fulfill the following directives[26]:
- License, inspect, and ensure the regulatory enforcement of health facilities;
- Investigate consumer complaints relating to health care facilities and managed care plans;

[23] Agency for Persons with Disabilities, *FY 2022-23 Reconciliation – Waiver Claims with Service Utilization*, available at: https://apd.myflorida.com/publications/reports/docs/FY22-23%20Q4%20Quarterly%20Reconciliation%20Waiver%20Claims%20and%20Service%20Utilization%2020230715.pdf (last visited March 31, 2025).
[24] Section 393.0662(14), F.S.
[25] Section 20.42, F.S.
[26] Section 20.42(3), F.S.

- Implement the certificate of need program;
- Operate the Florida Center for Health Information and Transparency;
- Administer the Medicaid program;
- Administer contracts with the Florida Healthy Kids Corporation;
- Certify health maintenance organizations and prepaid health clinics; and
- Complete any other duties prescribed by statute or agreement.

Statewide Medicaid Managed Care

States may offer Medicaid benefits through fee-for-service programs[27], managed care plans[28], or both.[29] In Florida, most Medicaid recipients are enrolled in the Statewide Medicaid Managed Care (SMMC) program.[30] The SMMC program consists of the following components[31]:

- Managed Medical Assistance (MMA): Provides Medicaid covered medical services such as doctor visits, hospital care, prescribed drugs, mental health care, and transportation to these services. Most people on Medicaid will receive their care from a plan that covers MMA services.
- Long-Term Care (LTC): Provides Medicaid LTC services like care in a nursing facility, assisted living facility, or at home for individuals that are at least 18 years old and meet nursing home level of care (or meet hospital level of care if the individual has Cystic Fibrosis).
- Dental: Provides all Medicaid dental services for children and adults. All individuals on Medicaid must enroll in a dental plan.

The AHCA competitively procures contracts with managed care plans to provide services to individuals under the SMMC.[32] Services may be provided by a health maintenance organization (HMO) or a provider service network (PSN).[33] Under a managed care system, HMOs consist of prepaid health care plans, where health care services are provided directly to a group of people who make regular premium payments.[34] PSNs are networks operated by a health care provider,

[27] Under fee-for-service models, the state pays providers directly for each covered service received by a Medicaid beneficiary. *See* Medicaid and CHIP Payment and Access Commission, *Provider payment and delivery systems*, available at: https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/#:~:text=Under%20the%20FFS%20model%2C%20the,person%20enrolled%20in%20the%20plan (last visited March 31, 2025).
[28] Under managed care plans, the state pays a fee to a managed care plan for each person enrolled in the plan. Health care providers are paid by the managed care plan, rather than the state directly, if the services are covered under the managed care plan's contract with the state. *See* Medicaid and CHIP Payment and Access Commission, *Provider payment and delivery systems*, available at: https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/#:~:text=Under%20the%20FFS%20model%2C%20the,person%20enrolled%20in%20the%20plan (last visited March 31, 2025).
[29] Medicaid and CHIP Payment and Access Commission, *Provider payment and delivery systems*, available at: https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/#:~:text=Under%20the%20FFS%20model%2C%20the,person%20enrolled%20in%20the%20plan (last visited March 31, 2025).
[30] Agency for Health Care Administration, *Statewide Medicaid Managed Care*, available at: https://flmedicaidmanagedcare.com/health/comparehealthplans (last visited March 31, 2025).
[31] *Id.*
[32] Section 409.967, F.S.
[33] Section 409.901(13), F.S.
[34] Section 641.18, F.S.

or a group of affiliated health care providers, who must have a controlling interest in the governing body of the PSN.[35] The health care providers that operate the PSN directly provide a substantial proportion of the health care items and services under a contract and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions.[36] PSNs receive per-member, per-month payments.[37]

Within the SMMC program, the AHCA has contracts with eight different managed care plans (referred to as "health plans").[38] All health plans are required to cover specified minimum services under the MMA, LTC, and Dental programs, as follows[39]:

MMA Minimum Covered Services	
Advanced registered nurse practitioner services	Hospital Inpatient and Outpatient Services
Ambulatory surgical treatment center services	Laboratory and Imaging Services
Assistive Care Services	Medical supply, equipment, protheses, and orthoses
Behavioral Health	Medical Foster Care
Birthing center services	Mental health services
Chiropractic services	Nursing care
Early intervention services	Nursing facility services for enrollees not in the LTC program
Early periodic screening diagnosis and treatment services for recipients under 21	Optical services and supplies
Emergency services	Optometrist services
Family planning services and supplies (some exception); Healthy Start Services (some exceptions)	Physical, occupational, respiratory, and speech therapy
Hearing services	Podiatric services
Home health agency services	Physician services, including physician assistant services
Hospice services	Rural health clinic services
Prescription drugs	Transportation to access covered services
Renal dialysis services	Substance abuse treatment
Respiratory equipment and supplies	

[35] Section 409.912, F.S.
[36] *Id*.
[37] *Id*.
[38] Agency for Health Care Administration, *SMMC Health Plans 2025-2030*, available at: https://ahca.myflorida.com/content/download/25039/file/27061%20SMMC%20Plan%20Poster%2002042025.pdf (last visited April 1, 2025).
[39] *Id.*

LTC Minimum Covered Services	
Adult companion care	Intermittent and skilled nursing
Adult day health care	Medical equipment and supplies
Assisted living	Medication administration
Assistive care services	Medication management
Attendant care	Nursing facility
Behavioral management	Nutritional assessment/risk reduction
Care coordination/Care management	Personal care
Caregiver training	Personal emergency response system
Home accessibility adaptation	Respite care
Home-delivered meals	Therapies: occupational, physical, respiratory, and speech
Homemaker	Transportation, Non-emergency
Hospice	
Dental Minimum Covered Services	
Ambulatory Surgical Center or Hospital-based Dental Services	Orthodontics
Dental Exams	Periodontics
Dental Screenings	Prosthodontics (dentures)
Dental X-rays	Root Canals
Extractions	Sealants
Fillings and Crowns	Sedation
Fluoride	Space Maintainers
Oral Health Instructions	Teeth Cleaning

Each health plan has expanded benefits that are provided in addition to the minimum covered services that the SMMC must provide.[40] This provides individuals with flexibility in their selection of health plans based on their coverage needs and the regions in which they reside.

Intellectual and Developmental Disabilities Pilot Program

In 2023, the Legislature directed the AHCA to implement a pilot program for up to 600 individuals with developmental disabilities in Regions D and I[41] who are on the APD preenrollment list.[42] The Intellectual and Developmental Disabilities (IDD) Pilot Program is voluntary and allows individuals who are currently in preenrollment category 1 through 6—who have been waiting for iBudget services—the opportunity to receive services through an

[40] Agency for Health Care Administration, *Health Plan Expanded Benefits Grid 2025*, available at: https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/new-smmc-program/information-for-recipients (last visited April 1, 2025).
[41] Region D includes Hillsborough, Polk, Manatee, Hardee, and Highlands counties and Region I includes Miami-Dade and Monroe counties. Agency for Health Care Administration, *New Medicaid Pilot Program serving more people with IDD*, available at: https://ahca.myflorida.com/site/medicaid/statewide-medicaid-managed-care/idd-pilot-program (last visited April 1, 2025).
[42] Ch. 2023-243, L.O.F.

integrated managed care delivery model.[43] To qualify for participation in the IDD Pilot Program, an applicant must meet the following criteria[44]:

- Be 18 years or older;
- Be in Categories 1–6 of the iBudget waiver;
- Meet Level of Care criteria for placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
- Be Medicaid-eligible under a qualifying category;
- Have a qualifying diagnosis, including:
  - The individual's intelligence quotient (IQ) is 59 or less; or
  - The individual's IQ is 60-70 inclusive and the individual has a secondary handicapping condition that includes: Down syndrome; Cerebral palsy; Prader-Willi Syndrome; Spina bifida; Epilepsy; Autism; or ambulation, sensory, chronic health, and behavioral problems; or has an IQ of 60-70 inclusive and the individual has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; or
  - The individual is eligible under the category of Autism, Cerebral Palsy, Down Syndrome, Prader-Willi Syndrome or Spina bifida and the individual has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.
- Reside in Region D or Region I of the pilot program.

The following services are included in the IDD Pilot Program[45]:

Covered Services in the IDD Pilot Program		
Adult Day Health Care	Adult Dental Services	Assisted Living
Behavior Analysis Services	Behavior Assistant Services	Care Coordination
Dietitian Services	Environmental Accessibility Adaptations	Equipment and Supplies
Home Delivered Meals	Life Skills Development Level 1 – Companion	Life Skills Development Level 2 – Supported Employment
Life Skills Development Level 3 – Adult Day Training	Life Skills Development Level 4 – Prevocational Services	Medical Services
Medication Administration	Medication Management	Occupational Therapy

[43] Agency for Health Care Administration, *New Medicaid Pilot Program serving more people with IDD*, available at: https://ahca.myflorida.com/site/medicaid/statewide-medicaid-managed-care/idd-pilot-program (last visited April 1, 2025).
[44] Agency for Health Care Administration, *Comprehensive Intellectual and Developmental Disabilities Managed Care Waiver*, available at: https://ahca.myflorida.com/site/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/comprehensive-intellectual-and-developmental-disabilities-managed-care-waiver (last visited April 1, 2025).
[45] *Id.*

Covered Services in the IDD Pilot Program (continued)		
Personal Emergency Response Systems	Personal Supports	Physical Therapy
Private Duty Nursing	Professional and Home Care Services	Residential Habilitation
Residential Nursing	Respiratory Therapy	Respite
Skilled Nursing	Specialized Medical Equipment and Supplies	Specialized Medical Home Care
Specialized Mental Health Counseling	Speech Therapy	Supported Living Coaching
Therapy Services	Transportation	Unpaid Caregiver Training
Vaccines		

The AHCA received federal approval for the home and community-based services waiver to implement the IDD Pilot Program on March 21, 2024.[46] Following the competitive procurement process, the AHCA awarded a contract to Florida Community Care, Inc. (FCC) to provide services in Regions D and I.[47] The AHCA assessed the FCC's plan policies, procedures, systems, and operations to determine FCC's readiness to support enrollees upon program launch.[48] Additionally, the APD provided training to FCC care coordinators and determined eligibility to participate in the IDD Pilot Program.[49]

The enrollment process for the IDD Pilot Program is as follows:[50]

- The APD identifies potential eligible individuals from iBudget preenrollment categories 1-6.
- The APD sends interest forms to potentially eligible individuals.
- Eligible individuals who are interested in the IDD Pilot Program enrollment return the interest form.
- The APD contacts interested persons to verify Medicaid eligibility, complete a Questionnaire for Situational Information (QSI) assessment, and complete the HCBS form.
- The APD forwards the names of eligible, interested individuals to the AHCA.
- The AHCA sends the FCC enrollment files and notifies enrollees.
- The FCC sends welcome letters, calls enrollees, schedules visits, develops care plans, and begins services.

The APD mailed interest letters to potentially eligible individuals in August 2024. There have not been additional reports of ongoing communication with potentially eligible individuals about

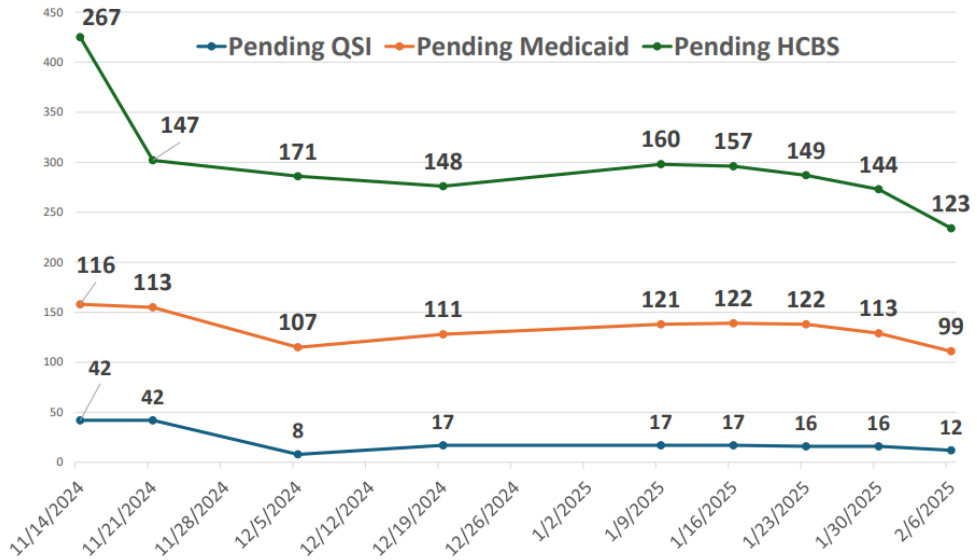
[46] Medicaid.gov, *FL Comprehensive Intellectual and Developmental Disabilities Managed Care Pilot Program (2346.R00.00)*, available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/161736 (last visited April 2, 2025).
[47] Agency for Health Care Administration, *Intellectual and Developmental Disabilities Managed Care Pilot Program*, available at: https://ahca.myflorida.com/content/download/25753/file/2024%20IDD%20Managed%20Care%20Pilot%20Status%20Report.pdf (last visited April 2, 2025).
[48] *Id.*
[49] *Id.*
[50] Agency for Health Care Administration and Florida Community Care, *Health and Human Services Committee Presentations*, February 11, 2025.

the pilot program after the initial letters were sent.[51] This contrasts with the current method of enrollment in the SMMC plans, which involves ongoing communication between the AHCA and enrollees of the SMMC.[52]

The FCC has reported the enrollment process for interested individuals faces several barriers.[53] Delays in the enrollment process may be attributed to a lack of coordination between the entities involved in the enrollment process. Currently, the AHCA and the FCC are not provided with an interested individual's file until the APD assesses an individual's needs. Currently, the APD is required to approve a needs assessment methodology to assist the APD in determining eligibility.[54] The APD utilizes the QSI assessment authorized for assessment of iBudget enrollees.[55] However, the AHCA's contract with the FCC requires the FCC to conduct an additional needs assessment of an individual within five business days *after* enrollment.[56] The APD does not have a similar deadline for the assessment. Thus, an individual's enrollment may be delayed while waiting for the APD to conduct the QSI; further, the individual will have to take another needs assessment by the FCC after enrollment.

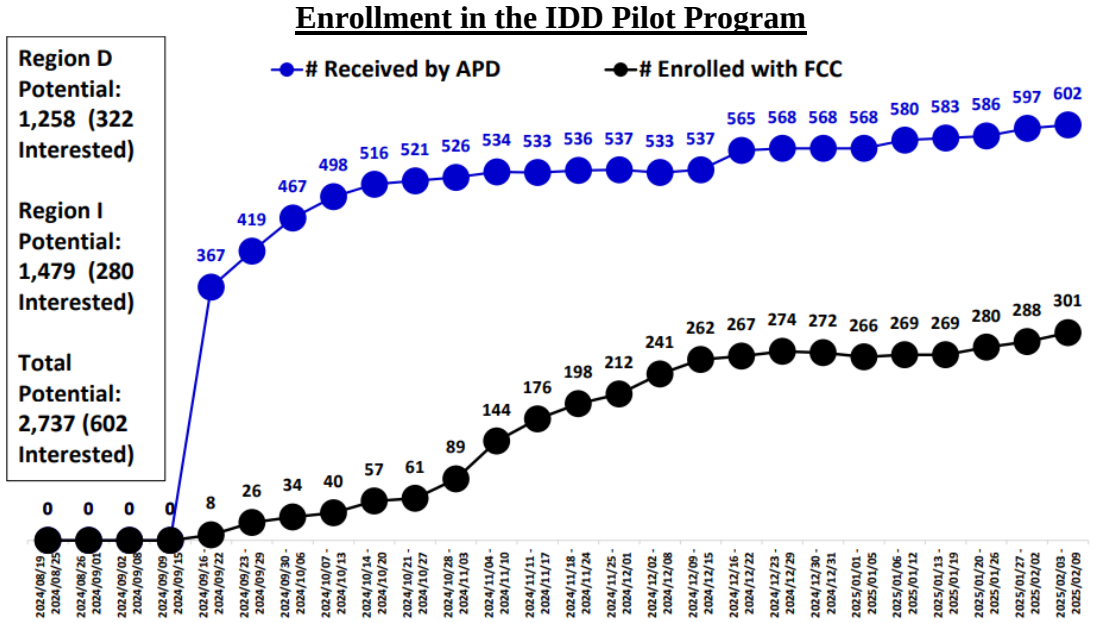
The following chart displays the individuals who are interested in the IDD Pilot Program, but their QSI, Medicaid eligibility, and HCBS waiver are pending from the APD:[57]

Enrollment Progress



[51] Agency for Health Care Administration and Florida Community Care, *Health and Human Services Committee Presentations*, February 11, 2025.
[52] Agency for Health Care Administration, *Enrolling in a Health Plan*, available at: https://www.flmedicaidmanagedcare.com/health/enroll (last visited April 2, 2025).
[53] *Supra, Note 51.*
[54] Section 409.9855(2)(b), F.S.
[55] The QSI is only authorized for utilization in the iBugdet program, not the IDD Pilot Program. *See* Section 393.0662, F.S.
[56] *Supra, Note 51.*
[57] *Id.*

Since October, over 600 individuals have expressed interest in the pilot program. As of early February, half of the interested individuals have enrolled in the pilot program with the FCC, as shown below:[58]



Consumer-Directed Care

In 2002, the Legislature directed the AHCA to establish the consumer-directed care program.[59] The program is based on the principles of consumer choice and control and allows enrolled persons to choose their providers and direct the delivery of services to best meet their long-term care needs.[60] Individuals that are enrolled in one of the Medicaid home and community-based waiver programs, including the iBudget program, are eligible to participate in consumer-directed care.[61]

Effect of the Proposed Changes

Section 5 amends the IDD Pilot Program under s. 409.9855, F.S.

The bill removes the requirement for the AHCA to administer the pilot program in consultation with the APD.

The bill expands the IDD Pilot Program in three phases:

- Immediately expands eligibility to individuals in *all* iBudget preenrollment categories (rather than Categories 1- 6) in Regions D or I.

[58] Agency for Health Care Administration and Florida Community Care, *Health and Human Services Committee Presentations*, February 11, 2025.
[59] Chapter 2002-223, L.O.F.
[60] Section 409.221(4), F.S.
[61] Section 409.221, F.S. and Agency for Health Care Administration, Florida Medicaid's Covered Services and HCBS Waivers, available at: https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/florida-medicaid-s-covered-services-and-hcbs-waivers (last visited March 13, 2025).

- Effective October 1, 2025, expands eligibility to individuals in all iBudget preenrollment categories in *any region*.
- Effective July 1, 2026, expands eligibility to individuals enrolled in the iBudget program or the LTC managed care program, regardless of region.

The bill requires the APD to transmit the following data to the AHCA weekly:
- Data files of clients enrolled in the Medicaid HCBS waiver program; and
- Clients in iBudget preenrollment categories.

The bill requires the AHCA to maintain a record of individuals with developmental disabilities who may be eligible for the pilot program using this data, Medicaid enrollment data transmitted by the DCF, and any available collateral data.

The bill places the AHCA in charge of administering the enrollment process and specifies that a needs assessment conducted by the APD is not required for enrollment. The bill codifies current contractual obligations of the participating plans to conduct an individualized assessment of each enrollee within five days after enrollment to determine the enrollee's functional, behavioral, and physical needs. The bill requires the AHCA to approve this assessment method or instrument.

The bill requires the AHCA to notify individuals with developmental disabilities of the opportunity to voluntarily enroll in the pilot program and provide them with the following information:
- The benefits available through the pilot program;
- The process for enrollment; and
- The procedures for disenrollment from the pilot program, including the requirement for continued coverage after disenrollment.

The bill requires the AHCA to provide a call center staffed by agents trained to assist individuals with developmental disabilities and their families in learning about and enrolling in the pilot program.

The bill requires the AHCA to coordinate with the DCF and the APD to develop partnerships with community-based organizations to disseminate information about the pilot program to providers of covered services and potential enrollees.

The bill clarifies additional benefits that must be provided in the IDD Pilot Program, negotiated by the AHCA. Providers of these benefits must meet the provider qualifications established by the AHCA for the Medicaid LTC managed care program. If no such qualifications apply to a specific benefit or provider type, the bill requires the provider to meet the provider qualifications established by the APD for the iBudget waiver services program.

The bill requires participating plans to offer a consumer-directed services option to individuals with developmental disabilities.

The bill requires the AHCA to monitor and evaluate the IDD Pilot Program and require corrective actions or payment of penalties as needed to secure compliance with contractual requirements. Such contractual requirements include, but are not limited to, the following:

- Compliance with provider network standards;
- Financial accountability;
- Performance standards;
- Health care quality improvement systems; and
- Program integrity.

The bill updates the reporting requirements for the AHCA. The bill removes the requirement for the AHCA to consult with the APD and updates the date of required reports, as follows:

- Requires a status report on progress made toward federal approval of the waiver or waiver amendment necessary by August 30, 2025, rather than December 31, 2023.
- Requires a status report on pilot program implementation by December 31, 2025, rather than December 31, 2024.

The bill makes conforming changes throughout the section to remove the requirement for the AHCA to consult with the APD for the administration of the IDD Pilot Program.

Adult Pathways Waiver Program

Present Situation

Adult Pathways Program

In 2024, the Legislature directed the AHCA and the APD to jointly develop a comprehensive plan for the administration, finance, and delivery of home and community-based services through a new home and community-based services Medicaid waiver program.[62] The waiver is intended for clients transitioning into adulthood, and designed to prevent future crisis enrollment (Category 1) in the iBudget program.

To fulfill the legislative directive from the 2024 legislative session, the APD and the AHCA contracted for an actuarial analysis to propose recommendations for the advancement of an Adult Pathways Waiver.[63]

In November 2024, the APD submitted the actuarial analysis and plan for the Adult Pathways Waiver. The waiver is intended to focus on a population of individuals with developmental disabilities ages 18 to 32 that have graduated or completed high school equivalency and are Medicaid eligible.[64] Additionally, the APD identified the following services to potentially include in the waiver[65]:

- Life Skills Developmental Level 1 (Community Inclusion)
- Like Skills Developmental Level 2 (Supported Employment)

[62] Ch. 2024-14, L.O.F.
[63] Ch. 2024-231, L.O.F. and Milliman Report, *Adult Pathways Waiver – Plans and Recommendations*, November 26, 2024 (on file with the Senate Committee on Children, Families, and Elder Affairs).
[64] *Id.*
[65] *Id.*

- Life Skills Developmental Level 3 (Adult Day Training)
- Life Skills Developmental Level 4 (Prevocational)
- Personal Supports
- Respite
- Support Coordination
- Supported Living Coaching
- Transportation

Residential habilitation and behavioral services were also identified as potential services for consideration.[66]

To begin implementation, the plan must receive legislative appropriation and be submitted for approval to the federal Centers for Medicare and Medicaid Services (CMS).[67]

Effect of Proposed Changes

Section 3 creates s. 393.0664, F.S., to implement the Adult Pathways Home and Community-Based Services Medicaid waiver (Adult Pathways) program using a fee-for-service model with an annual per-person funding cap. The program is designed to support individuals with developmental disabilities as they transition into adulthood and work toward greater independence.

Additionally, the bill requires the program to include a supplemental pathway that leverages natural supports and community partnerships to deliver services, manage costs, and proactively address client needs—ultimately aiming to prevent crises and improve overall health, safety, and well-being outcomes.

The bill authorizes the APD, in partnership with AHCA, to seek federal approval for the Adult Pathways program through a state plan amendment or Medicaid waiver. It requires AHCA to submit the request by October 1, 2025.

The bill requires participation in the program to be voluntary and limited to the maximum number of enrollees authorized in the GAA. The bill specifies the following criteria to participate in the program:

- Be eligible for Medicaid.
- Be eligible for a preenrollment category for Medicaid waiver services.
- Be 18 to 28 years of age at the time of enrollment and have attained a high school diploma or the equivalent.
- Meet the level of care required for home and community-based services as identified in the federal approval for the program.

The bill requires the APD to approve a needs assessment methodology to determine the functional, behavioral, and physical needs of prospective enrollees. This assessment

[66] Ch. 2024-231, L.O.F. and Milliman Report, *Adult Pathways Waiver – Plans and Recommendations,* November 26, 2024 (on file with the Senate Committee on Children, Families, and Elder Affairs).
[67] *Id*.

methodology must be administered by persons who have completed any training required by the APD for such purpose. The bill allows the APD to offer such training.

Enrollees may remain in the Adult Pathways program until age 32. Participation in the program does not impact an individual's status on the HCBS Medicaid waiver unless they voluntarily disenroll. If a participant leaves the program, the APD must place them back into the most appropriate preenrollment category based on a current needs assessment and established criteria.

The bill requires the APD to authorize covered services specified in the Medicaid waiver which are medically necessary, including, but not limited to, any of the following:

- Adult day training.
- Companion services.
- Employment services.
- Personal supports.
- Prevocational services.
- Supported living coaching.
- Transportation.
- Care Coordination.

The bill requires that services under the Adult Pathways program be delivered according to an individualized care plan, which must be evaluated and updated at least annually or more frequently if the enrollee's circumstances change.

Enrollment in the program must begin upon federal approval of the waiver, with coverage becoming effective once sufficient state and federal funding and resources are available.

The bill also authorizes the APD, in consultation with the AHCA, to make necessary program adjustments—such as modifying fees, reimbursement rates, service limits, or enrollment caps—based on available funding and guidance from the GAA.

The bill requires the APD, in consultation with the AHCA, to submit progress reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives upon federal approval of the Medicaid waiver and throughout implementation of the program. The bill requires the APD to submit a progress report by July 1, 2026, including, but not limited to, all of the following:

- The number of enrollees in the program and other pertinent information on enrollment.
- Service use.
- Average cost per enrollee.
- Outcomes and performance reporting relating to health, safety, and well-being of enrollees.

Family Care Councils

Present Situation

Family Care Councils

In 1993, the Legislature required each service district of the Department of Health and Rehabilitative Services[68] to create local family care councils (FCC).[69] FCCs are intended to facilitate the connection between government and individuals with disabilities and their families, to ensure that statewide policies are guided by input from individuals who are affected by such policies.[70]

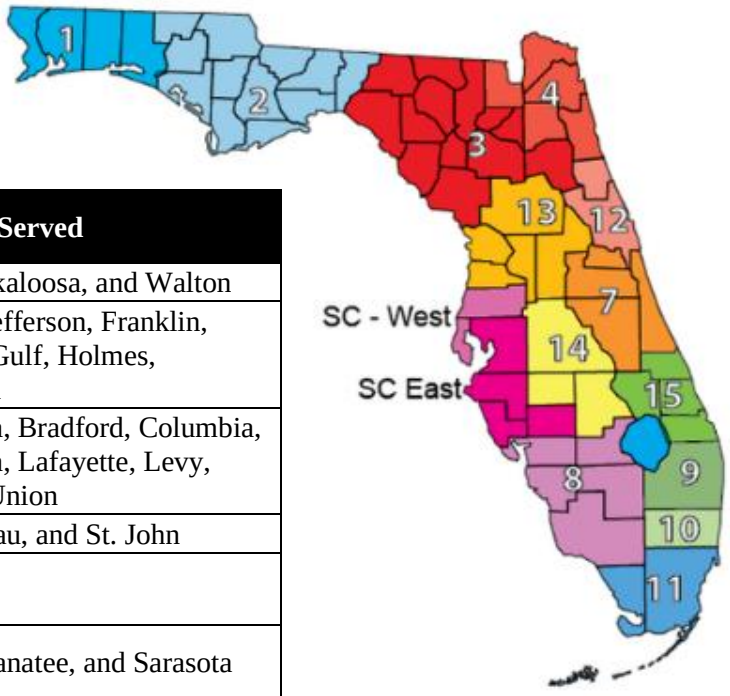
Current law requires local FCCs to consist of at least 10 members recommended by a majority vote of the local family care council and appointed by the Governor.[71] Council members must serve on a voluntary basis.[72] The FCC must be composed of individuals receiving or waiting to receive the APD services and family members of individuals with developmental disabilities.[73] FCCs are required to provide the APD-established training program to assist the council members in understanding the laws, rules, and policies applicable to their duties and responsibilities on the council.[74]

Family care councils are intended to advise the APD, develop a plan for the delivery of family support services within the local area, and to monitor the implementation and effectiveness of services and support provided under the developed plan.[75] The primary functions of the FCC are as follows:[76]

- Assist in providing information and outreach to families.
- Review the effectiveness of service programs and make recommendations with respect to program implementation.
- Advise the agency with respect to policy issues relevant to the community and family support system in the local area.
- Meet and share information with other local family care councils.

[68] The Department of Health and Rehabilitative Services was the entity originally responsible for operating programs for individuals with developmental disabilities (Ch. 96-175, L.O.F.). In 1996, the Department of Health and Rehabilitative Services was redesignated as the Department of Children and Family Services (Ch. 96-403, L.O.F). In 2004, the Legislature removed the oversight of programs related to developmental disabilities from the Department of Children and Family Services and established an agency, housed administratively within the DCF, to oversee the provisions of services to individuals with developmental disabilities, known as the Agency for Persons with Disabilities (Ch. 2004-267, L.O.F.). In 2012, the Department of Children and Family Services was renamed as the Department of Children and Families (Ch. 2012-84, L.O.F.).
[69] Ch. 93-143, L.O.F.
[70] Family Care Councils, *Serving Families for 30 Years*, available at: https://www.fccflorida.org/ (last visited March 26, 2025).
[71] Section 393.502, F.S.
[72] *Id.*
[73] *Id.*
[74] Section 393.502(5), F.S.
[75] Section 393.502(7), F.S.
[76] *Id.*

There are currently 15 FCCs statewide, as shown below:[77]



Local FCC	Counties Served
Area 1	Escambia, Santa Rosa, Okaloosa, and Walton
Area 2	Bay, Jackson, Calhoun, Jefferson, Franklin, Leon, Gadsden, Liberty, Gulf, Holmes, Washington, and Wakulla
Area 3	Madison, Taylor, Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union
Area 4	Baker, Clay, Duval, Nassau, and St. John
Suncoast West	Pasco and Pinellas
Suncoast East	DeSoto, Hillsborough, Manatee, and Sarasota
Area 7	Brevard, Seminole, Orange, and Osceola
Area 8	Charlotte, Collier, Glades, Hendry, and Lee
Area 9	Palm Beach
Area 10	Broward
Area 11	Dade and Monroe
Area 12	Flagler and Volusia
Area 13	Citrus, Hernando, Lake, Marion, and Sumter
Area 14	Hardee, Highlands, and Polk
Area 15	Indian River, Martin, Okeechobee, St. Lucie

Upon the establishment of a new FCC, the Governor must appoint the first four council members, who serve 3-year terms. The appointed members are required to submit recommendations for at least six additional members selected by a majority vote to the Governor.[78]

FCCs may apply for, receive, and accept grants, gifts, donations, bequests, and other payments from any public or private entity or person.[79] The APD may conduct an annual financial review of each local family care council.[80]

[77] Family Care Councils, *Local Family Care Councils,* available at: https://www.fccflorida.org/local-councils.html (last visited March 26, 2025).
[78] Section 393.502(8), F.S.
[79] *Id.*
[80] *Id.*

Effect of Proposed Changes

Section 4 of the bill amends s. 393.502, F.S., to establish a statewide family care council that coordinates with existing local family care councils and facilitates direct communication between local FCCs and the APD. The goal of the statewide FCC is to enhance the quality of and access to resources and supports for individuals with disabilities and their families.

The bill outlines the responsibilities of the statewide FCC, which include:
- Reviewing reports, policy proposals, and recommendations from local FCCs.
- Advising the APD on statewide policies, programs, and service improvements based on input from local councils.
- Identifying systemic service delivery barriers and recommending solutions.
- Promoting collaboration and sharing of best practices among local FCCs.
- Submitting an annual report by December 1 to the Governor, President of the Senate, Speaker of the House of Representatives, and the APD, summarizing local findings, policy suggestions, and evaluating the APD's response to prior recommendations.

Additionally, the APD must respond within 60 days of receiving the report, indicating whether it will implement the recommendations, providing a timeline or justification, and including a detailed action plan outlining steps taken or planned to address the recommendations.

The bill prohibits the APD or the AHCA employees from serving as voting members on either the statewide council or a local council. The bill maintains the membership structure of local FCCs and creates requirements for the membership of the statewide council.

The bill requires the statewide family care council to consist of the following members, appointed by the Governor:
- One representative from each of the local family care council, who must be a resident of the area served by that local council.
  - Among these representatives must be at least one individual who receives waiver services from the agency and at least one individual who is assigned to a preenrollment category for waiver services under s. 393.065, F.S.
- One individual representing an advocacy organization representing individuals with disabilities.
- One representative of a public or private entity that provides services to individuals with developmental disabilities that does not have a Medicaid waiver service contract with the APD.

The bill establishes membership and operational guidelines for the statewide FCC, including:
- Initial appointments are staggered for two- or four-year terms, with all subsequent terms set at four years. Members may serve only one additional consecutive term. After serving two consecutive terms, a member must wait at least 12 months before being reappointed.
- The statewide council must recommend at least one candidate for a vacancy to the Governor, who must make the appointment within 45 days. If the Governor does not act, the local council chair may appoint a qualified individual to serve until the Governor makes an official appointment.

- The statewide council must meet at least quarterly, either in person or virtually. Local councils must continue to meet six times per year, with flexibility to meet in person, by teleconference, or through other electronic means.
- The initial chair of the statewide council is appointed by the Governor. Future chairs are to be elected annually by a majority vote of council members.
- Council members do not receive compensation, but may be reimbursed for travel and per diem expenses as allowed pursuant to s. 112.061, F.S.

The bill clarifies language that provides the location of local family care councils, to agency-designated regions rather than service areas of the APD. The bill requires local family care councils to work constructively with the APD, advise the APD on local needs, identify gaps in services, and advocate for individuals with developmental disabilities and their families. Specifically, local family care councils are required to do the following:

- Assist in providing information and conducting outreach to individuals with developmental disabilities and their families.
- Convene family listening sessions at least twice a year to gather input on local service delivery challenges.
- Hold a public forum every six months to solicit public feedback concerning actions taken by the local FCCs.
- Identify policy issues relevant to the community and family support system in the region.
- Submit a report to the statewide family care council by September 1 each year. This report must detail proposed policy changes, program, recommendations, and identified service delivery challenges within its region.

The bill requires each local FCC chair to establish a family-led nominating committee composed of individuals receiving or waiting to receive APD services, or their relatives. These committee members do not need to be part of the local council. They are responsible for nominating candidates to fill council vacancies.

The bill requires local councils must vote to recommend candidates to the Governor based on the nominating committee's suggestions. The Governor has 45 days to make an appointment. If no action is taken, the local council may select an interim appointee from the recommended candidates by majority vote.

The bill allows the chair of the local FCC to appoint persons to serve on additional council committees. Such persons may include current members of the council, former members of the council, and persons not eligible to serve on the council.

The bill allows the statewide and local FCCs to apply for, receive, and accept funding and does not specify requirements regarding the purpose of the funding.

The bill allows the APD to make additional training available to the statewide and local council members.

The bill requires the APD to publish on its website all annual reports submitted by the local FCCs and the statewide council within 15 days after receipt of such reports in a designated and easily accessible section of the website.

The bill requires the APD to provide administrative support to the statewide council and local councils, including, but not limited to, staff assistance and meeting facilities, within existing resources.

Effective Date

Section 6 provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None Identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The expansion of the Intellectual and Developmental Disabilities (IDD) Pilot Program may have a significant, yet indeterminate, negative fiscal impact on the Agency for Health Care Administration (AHCA), contingent on whether the Legislature provides additional funding in the General Appropriations Act (GAA). The IDD Pilot Program's funding for Fiscal Year 2025-2026 totals $38.4 million ($16.4 million from the general revenue funds) to support 600 eligible individuals who voluntarily elect to participate in the pilot program.

The Legislature may also authorize the transfer of funds from the traditional waiver to the pilot program if an individual on the pre-enrollment list chooses to receive services through the pilot. This transfer would not require additional appropriations, as the Agency for Persons with Disabilities (APD) typically reverts waiver funds each fiscal year.

Providing administrative support for the new Statewide Family Care Council and participating in child welfare transition planning will have an insignificant, negative fiscal impact on APD which can be absorbed within existing resources.

The bill also requires that implementation of the Adult Pathways Home and Community-Based Services Medicaid waiver program remain voluntary and be limited to the maximum number of enrollees authorized in the GAA.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 393.0662, 393.065, 393.502, and 409.9855.

This bill creates section 393.0664 of the Florida Statutes.

IX. Additional Information:

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

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

- Requires the Agency for Persons with Disabilities (APD) to post quarterly reconciliation reports for the iBudget waiver.

- Changes requirements of the APD in relation to the online application for iBudget services and transition planning activities for individuals assigned to preenrollment category 2.
- Expands the Intellectual and Developmental Disabilities (IDD) Pilot Program.
- Clarifies the role of the Agency for Health Care Administration and the APD in administering the IDD Pilot Program, effectively removing the APD from the administration of the program.
- Clarifies the requirements of the statewide and local family care councils.
- Removes language requiring a type two transfer of the Division of Blind Services, the Division of Vocational Rehabilitation, and the Federal Rehabilitation Trust Fund from the Department of Education to the APD.
- Removes language designating the APD as a department.
- Removes language amending the membership of the Commission for the Transportation Disadvantaged.

B. Amendments:

None.

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

586-03168-25 20251050c1

A bill to be entitled

An act relating to services for individuals with developmental disabilities; amending s. 393.0662, F.S.; requiring the Agency for Persons with Disabilities to post its quarterly reconciliation reports on its website within a specified timeframe; amending s. 393.065, F.S.; providing a requirement for the online application system to allow an applicant to apply for crisis enrollment; removing a requirement for the agency to remove certain individuals from the preenrollment categories under certain circumstances; requiring the agency to participate in transition planning activities and to post the total number of individuals in each priority category on its website; creating s. 393.0664, F.S.; requiring the agency to implement a specified Medicaid waiver program to address the needs of certain clients; providing the purpose of the program; authorizing the agency, in partnership with the Agency for Health Care Administration, to seek federal approval through a state plan amendment or Medicaid waiver to implement the program by a specified date; providing voluntary enrollment, eligibility, and disenrollment requirements; requiring the agency to approve a needs assessment methodology; providing that only persons trained by the agency may administer the methodology; requiring the agency to offer such training; requiring the agency to authorize certain covered services specified in the Medicaid waiver; providing

Florida Senate - 2025 CS for SB 1050

586-03168-25 20251050c1

requirements for such services; requiring the agency to begin enrollment in the program upon federal approval; providing construction; requiring the agency, in consultation with the Agency for Health Care Administration, to submit progress reports to the Governor and the Legislature upon federal approval and throughout implementation of the program; requiring the agency to submit, by a specified date, a progress report on the administration of the program; specifying requirements for the report; amending s. 393.502, F.S.; establishing the Statewide Family Care Council; providing for the purpose, membership, and duties of the council; requiring local family care councils to report to the statewide council policy changes and program recommendations in an annual report; providing for appointment of council members; providing for the creation of family-led nominating committees; providing duties of the agency relating to the statewide council and local councils; amending s. 409.9855, F.S.; revising implementation and eligibility requirements of the pilot program for individuals with developmental disabilities; requiring the Agency for Persons with Disabilities to transmit to the Agency for Health Care Administration weekly data files of specified clients; requiring the Agency for Health Care Administration to provide a call center for specified purposes and to coordinate with the Department of Children and Families and the Agency for Persons with Disabilities to disseminate

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

information about the pilot program; revising pilot program benefits; revising provider qualifications; requiring participating plans to conduct an individualized assessment of each enrollee within a specified timeframe for certain purposes and to offer certain services to such enrollees; requiring the Agency for Health Care Administration to conduct monitoring and evaluations and require corrective actions or payment of penalties under certain circumstances; removing coordination requirements for the agency when submitting certain reports, establishing specified measures, and conducting quality assurance monitoring of the pilot program; revising dates for submitting certain status reports; providing an effective date.

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

Section 1. Subsection (14) of section 393.0662, Florida Statutes, is amended to read:

393.0662 Individual budgets for delivery of home and community-based services; iBudget system established.—The Legislature finds that improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for enrollment in the program. The Legislature further finds that clients and their families should have greater flexibility to choose the services that best allow them to live in their

community within the limits of an established budget. Therefore, the Legislature intends that the agency, in consultation with the Agency for Health Care Administration, shall manage the service delivery system using individual budgets as the basis for allocating the funds appropriated for the home and community-based services Medicaid waiver program among eligible enrolled clients. The service delivery system that uses individual budgets shall be called the iBudget system.

(14)(a) The agency, in consultation with the Agency for Health Care Administration, shall provide a quarterly reconciliation report of all home and community-based services waiver expenditures from the Agency for Health Care Administration's claims management system with service utilization from the Agency for Persons with Disabilities Allocation, Budget, and Contract Control system. The reconciliation report must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than 30 days after the close of each quarter.

(b) The agency shall post its quarterly reconciliation reports on its website, in a conspicuous location, no later than 5 days after submitting the reports as required in this subsection.

Section 2. Present subsection (12) of section 393.065, Florida Statutes, is redesignated as subsection (13), paragraph (a) of subsection (1), paragraph (b) of subsection (5), and subsection (10) of that section are amended, and a new subsection (12) is added to that section, to read:

393.065 Application and eligibility determination.—

(1)(a) The agency shall develop and implement an online application process that, at a minimum, supports paperless, electronic application submissions with immediate e-mail confirmation to each applicant to acknowledge receipt of application upon submission. The online application system must allow an applicant to review the status of a submitted application and respond to provide additional information. The online application must allow an applicant to apply for crisis enrollment.

(5) Except as provided in subsections (6) and (7), if a client seeking enrollment in the developmental disabilities home and community-based services Medicaid waiver program meets the level of care requirement for an intermediate care facility for individuals with intellectual disabilities pursuant to 42 C.F.R. ss. 435.217(b)(1) and 440.150, the agency must assign the client to an appropriate preenrollment category pursuant to this subsection and must provide priority to clients waiting for waiver services in the following order:

(b) Category 2, which includes clients in the preenrollment categories who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system into permanency; or

b. At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or

2. At least 18 years but not yet 22 years of age and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the

extended foster care system.

For individuals who are at least 18 years but not yet 22 years of age and who are eligible under sub-subparagraph 1.b., the agency must provide waiver services, including residential habilitation, and must actively participate in transition planning activities, including, but not limited to, individualized service coordination, case management support, and ensuring continuity of care pursuant to s. 39.6035. The community-based care lead agency must fund room and board at the rate established in s. 409.145(3) and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

Within preenrollment categories 3, 4, 5, 6, and 7, the agency shall prioritize clients in the order of the date that the client is determined eligible for waiver services.

(10) The client, the client's guardian, or the client's family must ensure that accurate, up-to-date contact information is provided to the agency at all times. Notwithstanding s. 393.0651, the agency must send an annual letter requesting updated information from the client, the client's guardian, or the client's family. ~~The agency must remove from the preenrollment categories any individual who cannot be located using the contact information provided to the agency, fails to meet eligibility requirements, or becomes domiciled outside the state.~~

(12) To ensure transparency and timely access to information, the agency shall post on its website in a conspicuous location the total number of individuals in each priority category. The posted numbers shall reflect the current status of the preenrollment priority list and shall be updated at least every 5 days.

Section 3. Section 393.0664, Florida Statutes, is created to read:

393.0664 Adult Pathways Home and Community-based Services Medicaid waiver program.—

(1) PROGRAM IMPLEMENTATION.—

(a) The agency shall implement the Adult Pathways Home and Community-based Services Medicaid waiver program using a fee-for-service model with an annual per-person funding cap to address the needs of clients with developmental disabilities as they transition into adulthood and achieve greater independence throughout their lifetimes.

(b) The program is created to establish an additional pathway to provide necessary supports and services to clients and contain costs by maximizing the use of natural supports and community partnerships before turning to state resources to meet the needs of clients at the earliest possible time to prevent care crises and to positively influence outcomes relating to client health, safety, and well-being.

(c) The agency, in partnership with the Agency for Health Care Administration, may seek federal approval through a state plan amendment or Medicaid waiver as necessary to implement the program. The Agency for Health Care Administration shall submit a request for any federal approval needed to implement the

program by October 1, 2025.

(2) VOLUNTARY ENROLLMENT; ELIGIBILITY; DISENROLLMENT.—

(a) Participation in the program is voluntary and limited to the maximum number of enrollees authorized in the General Appropriations Act.

(b) The agency shall approve a needs assessment methodology to determine functional, behavioral, and physical needs of prospective enrollees. The assessment methodology may be administered only by persons who have completed any training required by the agency for such purpose. If required, the agency must offer any such training.

(c) To participate in the program, a client must meet all of the following criteria:

1. Be eligible for Medicaid.

2. Be eligible for a preenrollment category for Medicaid waiver services as provided in s. 393.065(5).

3. Be 18 to 28 years of age at the time of enrollment and have attained a high school diploma or the equivalent.

4. Meet the level of care required for home and community-based services as identified in the federal approval for the program.

(d) Enrollees may remain on the Adult Pathways waiver until the age of 32.

(e) Participation in the program does not affect the status of current clients of the home and community-based services Medicaid waiver program under s. 393.0662 unless a client, or his or her legal representative, voluntarily disenrolls from that program.

(f) Enrollees who voluntarily disenroll from the program

must be allowed to return to the most appropriate preenrollment category for services under s. 393.065 based on a current needs assessment and the preenrollment category criteria.

(3) ADULT PATHWAYS WAIVER SERVICES.—

(a) The agency shall authorize covered services as specified in the Medicaid waiver which are medically necessary, including, but not limited to, any of the following:

1. Adult day training.

2. Companion services.

3. Employment services.

4. Personal supports.

5. Prevocational services.

6. Supported living coaching.

7. Transportation.

8. Care Coordination.

(b) Services must be provided to enrollees in accordance with an individualized care plan, which must be evaluated and updated at least annually and as often as warranted by changes in the enrollee's circumstances.

(4) PROGRAM ADMINISTRATION AND EVALUATION.—

(a) The agency shall begin enrollment upon federal approval of the Medicaid waiver, with coverage for enrollees becoming effective upon authorization and availability of sufficient state and federal funding and resources.

(b) This section and any rules adopted pursuant thereto may not be construed to prevent or limit the agency, in consultation with the Agency for Health Care Administration, from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services; limiting enrollment; or making any other

adjustment necessary based upon funding and any limitations imposed or directions provided in the General Appropriations Act.

(c) The agency, in consultation with the Agency for Health Care Administration, shall submit progress reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives upon federal approval of the Medicaid waiver and throughout implementation of the program under the waiver. By July 1, 2026, the Agency for Persons with Disabilities shall submit a progress report on the administration of the program, including, but not limited to, all of the following:

1. The number of enrollees in the program and other pertinent information on enrollment.

2. Service use.

3. Average cost per enrollee.

4. Outcomes and performance reporting relating to health, safety, and well-being of enrollees.

Section 4. Section 393.502, Florida Statutes, is amended to read:

393.502 Family care councils.—

(1) CREATION AND PURPOSE OF STATEWIDE FAMILY CARE COUNCIL.— ~~There shall be established and located within each service area of the agency a family care council.~~

(a) The Statewide Family Care Council is established to connect local family care councils and facilitate direct communication between local councils and the agency, with the goal of enhancing the quality of and access to resources and supports for individuals with developmental disabilities and

their families.

(b) The statewide council shall:

1. Review annual reports, policy proposals, and program recommendations submitted by the local family care councils.

2. Advise the agency on statewide policies, programs, and service delivery improvements based on the collective recommendations of the local councils.

3. Identify systemic barriers to the effective delivery of services and recommend solutions to address such barriers.

4. Foster collaboration and the sharing of best practices and available resources among local family care councils to improve service delivery across regions.

5. Submit an annual report no later than December 1 of each year to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the agency. The report shall include a summary of local council findings, policy recommendations, and an assessment of the agency's actions in response to previous recommendations of the local councils.

(c) The agency shall provide a written response within 60 days after receipt, including a detailed action plan outlining steps taken or planned to address recommendations. The response must specify whether recommendations will be implemented and provide a timeline for implementation or include justification if recommendations are not adopted.

(2) STATEWIDE FAMILY CARE COUNCIL MEMBERSHIP.—

(a) The statewide council shall consist of the following members appointed by the Governor:

1. One representative from each of the local family care councils, who must be a resident of the area served by that

local council. Among these representatives must be at least one individual who is receiving waiver services from the agency under s. 393.065 and at least one individual who is assigned to a preenrollment category for waiver services under s. 393.065.

2. One individual representing an advocacy organization representing individuals with disabilities.

3. One representative of a public or private entity that provides services to individuals with developmental disabilities that does not have a Medicaid waiver service contract with the agency.

(b) Employees of the agency or the Agency for Health Care Administration are not eligible to serve on the statewide council.

(3) STATEWIDE FAMILY CARE COUNCIL TERMS; VACANCIES.—

(a) Statewide council members shall be initially appointed to staggered 2- and 4-year terms, with subsequent terms of 4 years. Members may be reappointed to one additional consecutive term.

(b) A member who has served two consecutive terms shall not be eligible to serve again until at least 12 months have elapsed since ending service on the statewide council.

(c) Upon expiration of a term or in the case of any other vacancy, the statewide council shall, by majority vote, recommend to the Governor for appointment at least one person for each vacancy.

1. The Governor shall make an appointment within 45 days after receiving a recommendation from the statewide council. If the Governor fails to make an appointment for a member under subsection (2), the chair of the local council may appoint a

member meeting the requirements of subsection (2) to act as the statewide council representative for that local council until the Governor makes an appointment.

2. If no member of a local council is willing and able to serve on the statewide council, the Governor shall appoint an individual from another local council to serve on the statewide council.

(4) STATEWIDE FAMILY CARE COUNCIL MEETINGS; ORGANIZATION.—The statewide council shall meet at least quarterly. The council meetings may be held in person or via teleconference or other electronic means.

(a) The Governor shall appoint the initial chair from among the members of the statewide council. Subsequent chairs shall be elected annually by a majority vote of the council.

(b) Members of the statewide council shall serve without compensation but may be reimbursed for per diem and travel expenses pursuant to s. 112.061.

(c) A majority of the members of the statewide council shall constitute a quorum.

(5) LOCAL FAMILY CARE COUNCILS.—There is established and located within each service area of the agency a local family care council to work constructively with the agency, advise the agency on local needs, identify gaps in services, and advocate for individuals with developmental disabilities and their families.

(6) LOCAL FAMILY CARE COUNCIL DUTIES.—The local family care councils shall:

(a) Assist in providing information and conducting outreach to individuals with developmental disabilities and their

families.

(b) Convene family listening sessions at least twice a year to gather input on local service delivery challenges.

(c) Hold a public forum every 6 months to solicit public feedback concerning actions taken by the local family councils.

(d) Share information with other local family care councils.

(e) Identify policy issues relevant to the community and family support system in the region.

(f) Submit to the Statewide Family Care Council, no later than September 1 of each year, an annual report detailing proposed policy changes, program recommendations, and identified service delivery challenges within its region.

(7) ~~(2)~~ LOCAL FAMILY CARE COUNCIL MEMBERSHIP.—

(a) Each local family care council shall consist of at least 10 and no more than 15 members recommended by a majority vote of the local family care council and appointed by the Governor.

(b) At least three of the members of the council shall be individuals receiving or waiting to receive services from the agency. One such member shall be an individual who has been receiving services within the 4 years before the date of recommendation. The remainder of the council members shall be parents, grandparents, guardians, or siblings of individuals who have developmental disabilities and qualify for services pursuant to this chapter. For a grandparent to be a council member, the grandchild's parent or legal guardian must consent to the appointment and report the consent to the agency.

(c) A person who is currently serving on another board or

council of the agency may not be appointed to a local family care council.

(d) Employees of the agency or the Agency for Health Care Administration are not eligible to serve on a local family care council.

(e) Persons related by consanguinity or affinity within the third degree shall not serve on the same local family care council at the same time.

(f) A chair for the council shall be chosen by the council members to serve for 1 year. A person may not serve ~~no~~ more than four 1-year terms as chair.

(8) ~~(3)~~ LOCAL FAMILY CARE COUNCIL TERMS; VACANCIES.—

(a) Local family council members shall be appointed for ~~a~~ 3-year terms ~~term~~, except as provided in subsection (11) ~~(8)~~, and may be reappointed to one additional term.

(b) A member who has served two consecutive terms shall not be eligible to serve again until 12 months have elapsed since ending his or her service on the local council.

(c) 1. Upon expiration of a term or in the case of any other vacancy, the local council shall, by majority vote, recommend to the Governor for appointment a person for each vacancy based on recommendations received from the family-led nominating committee described in paragraph (9)(a).

2. The Governor shall make an appointment within 45 days after receiving a recommendation. If the Governor fails to make an appointment within 45 days the local council shall, by majority vote, may select an interim appointment for each vacancy from the panel of candidates recommended by the family-led nominating committee.

(9) ~~(4)~~ LOCAL FAMILY CARE COUNCIL COMMITTEE APPOINTMENTS.—

(a) The chair of each local family care council shall create, and appoint individuals receiving or waiting to receive services from the agency and their relatives, to serve on a family-led nominating committee. Members of the family-led nominating council need not be members of the local council. The family-led nominating committee shall nominate candidates for vacant positions on the local family council.

(b) The chair of the local family care council may appoint persons to serve on additional council committees. Such persons may include current members of the council and former members of the council and persons not eligible to serve on the council.

~~(5) TRAINING.—~~

~~(a) The agency, in consultation with the local councils, shall establish a training program for local family care council members. Each local area shall provide the training program when new persons are appointed to the local council and at other times as the secretary deems necessary.~~

~~(b) The training shall assist the council members to understand the laws, rules, and policies applicable to their duties and responsibilities.~~

~~(c) All persons appointed to a local council must complete this training within 90 days after their appointment. A person who fails to meet this requirement shall be considered to have resigned from the council.~~

(10) ~~(6)~~ LOCAL FAMILY CARE COUNCIL MEETINGS.—Local council members shall serve on a voluntary basis without payment for their services but shall be reimbursed for per diem and travel expenses as provided for in s. 112.061. Local councils ~~The~~

~~council~~ shall meet at least six times per year. Meetings may be held in person or by teleconference or other electronic means.

~~(7) PURPOSE.—The purpose of the local family care councils shall be to advise the agency, to develop a plan for the delivery of family support services within the local area, and to monitor the implementation and effectiveness of services and support provided under the plan. The primary functions of the local family care councils shall be to:~~

~~(a) Assist in providing information and outreach to families.~~

~~(b) Review the effectiveness of service programs and make recommendations with respect to program implementation.~~

~~(c) Advise the agency with respect to policy issues relevant to the community and family support system in the local area.~~

~~(d) Meet and share information with other local family care councils.~~

(11)~~(8)~~ NEW LOCAL FAMILY CARE COUNCILS.—When a local family care council is established for the first time in a local area, the Governor shall appoint the first four council members, who shall serve 3-year terms. These members shall submit to the Governor, within 90 days after their appointment, recommendations for at least six additional members, selected by majority vote.

(12)~~(9)~~ FUNDING; FINANCIAL REVIEW.—The statewide and local family care councils ~~council~~ may apply for, receive, and accept grants, gifts, donations, bequests, and other payments from any public or private entity or person. Each local council is subject to an annual financial review by staff assigned by the

agency. Each local council shall exercise care and prudence in the expenditure of funds. The local family care councils shall comply with state expenditure requirements.

(13) TRAINING.—

(a) The agency, in consultation with the statewide and local councils, shall establish and provide a training program for council members.

(b) The training shall assist the council members to understand the laws, rules, and policies applicable to their duties and responsibilities.

(c) All persons newly appointed to the statewide or a local council must complete this training within 90 days after their appointment. A person who fails to meet this requirement is considered to have resigned from the council. The agency may make additional training available to council members.

(14) DUTIES.—The agency shall publish on its website all annual reports submitted by the local care councils and the Statewide Family Care Council within 15 days after receipt of such reports in a designated and easily accessible section of the website.

(15) ADMINISTRATIVE SUPPORT.—The agency shall provide administrative support to the statewide council and local councils, including, but not limited to, staff assistance and meeting facilities, within existing resources.

Section 5. Subsections (1), (2), (3), and (6) of section 409.9855, Florida Statutes, are amended to read:

409.9855 Pilot program for individuals with developmental disabilities.—

(1) PILOT PROGRAM IMPLEMENTATION.—

(a) ~~Using a managed care model,~~ The agency shall implement a pilot program for individuals with developmental disabilities ~~in Statewide Medicaid Managed Care Regions D and I~~ to provide coverage of comprehensive services using a managed care model. The agency may seek federal approval through a state plan amendment or Medicaid waiver as necessary to implement the pilot program.

(b) The agency shall administer the pilot program pursuant to s. 409.903 and as a component of the Statewide Medicaid Managed Care model established by this section. Unless otherwise specified, ss. 409.961-409.969 apply to the pilot program. ~~The agency may seek federal approval through a state plan amendment or Medicaid waiver as necessary to implement the pilot program. The agency shall submit a request for any federal approval needed to implement the pilot program by September 1, 2023.~~

(c) ~~Pursuant to s. 409.963, the agency shall administer the pilot program in consultation with the Agency for Persons with Disabilities.~~

~~(d)~~ The agency shall make capitated payments to managed care organizations for comprehensive coverage, including managed medical assistance benefits and long-term care under this part and community-based services described in s. 393.066(3) ~~and approved through the state's home and community-based services Medicaid waiver program for individuals with developmental disabilities. Unless otherwise specified, ss. 409.961-409.969 apply to the pilot program~~.

~~(e) The agency shall evaluate the feasibility of statewide implementation of the capitated managed care model used by the pilot program to serve individuals with developmental~~

~~disabilities.~~

(2) ELIGIBILITY; VOLUNTARY ENROLLMENT; DISENROLLMENT.—

(a) Participation in the pilot program is voluntary and limited to the maximum number of enrollees specified in the General Appropriations Act.

(b) To be eligible for enrollment in the pilot program, an individual must ~~The Agency for Persons with Disabilities shall approve a needs assessment methodology to determine functional, behavioral, and physical needs of prospective enrollees. The assessment methodology may be administered by persons who have completed such training as may be offered by the agency. Eligibility to participate in the pilot program is determined based on all of the following criteria~~:

1. Be Medicaid eligible ~~Whether the individual is eligible for Medicaid~~.

2. Be ~~Whether the individual is~~ 18 years of age or older.

3. Have a developmental disability as defined in s. 393.063.

4. Be placed in any preenrollment category for individual budget waiver services under chapter 393 and reside in Statewide Medicaid Managed Care Regions D or I; effective October 1, 2025, be placed in any preenrollment category for individual budget waiver services under chapter 393, regardless of region; or, effective July 1, 2026, be enrolled in the individual budget waiver services program under chapter 393 or in the long-term care managed care program under this part, regardless of region ~~and is on the waiting list for individual budget waiver services under chapter 393 and assigned to one of categories 1 through 6 as specified in s. 393.065(5)~~.

~~3. Whether the individual resides in a pilot program region.~~

(c) The agency shall enroll individuals in the pilot program based on verification that the individual has met the criteria in paragraph (b).

1. The Agency for Persons with Disabilities shall transmit to the agency weekly data files of clients enrolled in the Medicaid home and community-based services waiver program under chapter 393 and clients in preenrollment categories pursuant to s. 393.065. The agency shall maintain a record of individuals with developmental disabilities who may be eligible for the pilot program using this data, Medicaid enrollment data transmitted by the Department of Children and Families, and any available collateral data.

2. The agency shall determine and administer the process for enrollment. A needs assessment conducted by the Agency for Persons with Disabilities is not required for enrollment. The agency shall notify individuals with developmental disabilities of the opportunity to voluntarily enroll in the pilot program and explain the benefits available through the pilot program, the process for enrollment, and the procedures for disenrollment, including the requirement for continued coverage after disenrollment pursuant to paragraph (d).

3. The agency shall provide a call center staffed by agents trained to assist individuals with developmental disabilities and their families in learning about and enrolling in the pilot program.

4. The agency shall coordinate with the Department of Children and Families and the Agency for Persons with

Disabilities to develop partnerships with community-based organizations to disseminate information about the pilot program to providers of covered services and potential enrollees.

(d) Notwithstanding any provisions of s. 393.065 to the contrary, an enrollee must be afforded an opportunity to enroll in any appropriate existing Medicaid waiver program if any of the following conditions occur:

1. At any point during the operation of the pilot program, an enrollee declares an intent to voluntarily disenroll, provided that he or she has been covered for the entire previous plan year by the pilot program.

2. The agency determines the enrollee has a good cause reason to disenroll.

3. The pilot program ceases to operate.

Such enrollees must receive an individualized transition plan to assist him or her in accessing sufficient services and supports for the enrollee’s safety, well-being, and continuity of care.

(3) PILOT PROGRAM BENEFITS.—

(a) Plans participating in the pilot program must, at a minimum, cover the following:

1. All benefits included in s. 409.973.

2. All benefits included in s. 409.98.

3. All benefits included in s. 393.066(3).

4. Any additional benefits negotiated by the agency pursuant to paragraph (4)(b)~~, and all of the following:~~

~~a. Adult day training~~.

~~b. Behavior analysis services.~~

~~c. Behavior assistant services.~~

~~d. Companion services.~~
~~e. Consumable medical supplies.~~
~~f. Dietitian services.~~
~~g. Durable medical equipment and supplies.~~
~~h. Environmental accessibility adaptations.~~
~~i. Occupational therapy.~~
~~j. Personal emergency response systems.~~
~~k. Personal supports.~~
~~l. Physical therapy.~~
~~m. Prevocational services.~~
~~n. Private duty nursing.~~
~~o. Residential habilitation, including the following levels:~~
~~(I) Standard level.~~
~~(II) Behavior-focused level.~~
~~(III) Intensive-behavior level.~~
~~(IV) Enhanced intensive-behavior level.~~
~~p. Residential nursing services.~~
~~q. Respiratory therapy.~~
~~r. Respite care.~~
~~s. Skilled nursing.~~
~~t. Specialized medical home care.~~
~~u. Specialized mental health counseling.~~
~~v. Speech therapy.~~
~~w. Support coordination.~~
~~x. Supported employment.~~
~~y. Supported living coaching.~~
~~z. Transportation.~~

(b) All providers of the benefits ~~services~~ listed under

paragraph (a) must meet the provider qualifications established by the agency for the Medicaid long-term care managed care program under this section. If no such qualifications apply to a specific benefit or provider type, the provider must meet the provider qualifications established by the Agency for Persons with Disabilities for the individual budget waiver services program under chapter 393 ~~outlined in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook as adopted by reference in rule 59G-13.070, Florida Administrative Code~~.

(c) Support coordination services must maximize the use of natural supports and community partnerships.

(d) The plans participating in the pilot program must provide all categories of benefits through a single, integrated model of care.

(e) Participating plans must provide benefits ~~services must be provided~~ to enrollees in accordance with an individualized care plan which is evaluated and updated at least quarterly and as warranted by changes in an enrollee's circumstances. Participating plans must conduct an individualized assessment of each enrollee within 5 days after enrollment to determine the enrollee's functional, behavioral, and physical needs. The assessment method or instrument must be approved by the agency.

(f) Participating plans must offer a consumer-directed services option in accordance with s. 409.221.

(6) PROGRAM IMPLEMENTATION AND EVALUATION.—

(a) The agency shall conduct monitoring and evaluations and require corrective actions or payment of penalties as may be necessary to secure compliance with contractual requirements,

consistent with its obligations under this section, including, but not limited to, compliance with provider network standards, financial accountability, performance standards, health care quality improvement systems, and program integrity ~~select participating plans and begin enrollment no later than January 31, 2024, with coverage for enrollees becoming effective upon authorization and availability of sufficient state and federal resources~~.

(b) ~~Upon implementation of the program, the agency, in consultation with the Agency for Persons with Disabilities, shall conduct audits of the selected plans' implementation of person-centered planning.~~

~~(c)~~ The agency~~, in consultation with the Agency for Persons with Disabilities,~~ shall submit progress reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives upon the federal approval, implementation, and operation of the pilot program, as follows:

1. By August 30, 2025 ~~December 31, 2023~~, a status report on progress made toward federal approval of the waiver or waiver amendment needed to implement the pilot program.

2. By December 31, 2025 ~~2024~~, a status report on implementation of the pilot program.

3. By December 31, 2025, and annually thereafter, a status report on the operation of the pilot program, including, but not limited to, all of the following:

a. Program enrollment, including the number and demographics of enrollees.

b. Any complaints received.

c. Access to approved services.

(c)~~(d)~~ The agency~~, in consultation with the Agency for Persons with Disabilities,~~ shall establish specific measures of access, quality, and costs of the pilot program. The agency may contract with an independent evaluator to conduct such evaluation. The evaluation must include assessments of cost savings; consumer education, choice, and access to services; plans for future capacity and the enrollment of new Medicaid providers; coordination of care; person-centered planning and person-centered well-being outcomes; health and quality-of-life outcomes; and quality of care by each eligibility category and managed care plan in each pilot program site. The evaluation must describe any administrative or legal barriers to the implementation and operation of the pilot program in each region.

1. The agency~~, in consultation with the Agency for Persons with Disabilities,~~ shall conduct quality assurance monitoring of the pilot program to include client satisfaction with services, client health and safety outcomes, client well-being outcomes, and service delivery in accordance with the client's care plan.

2. The agency shall submit the results of the evaluation to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2029.

Section 6. This act shall take effect July 1, 2025.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	SB 1060
INTRODUCER:	Senator Brodeur
SUBJECT:	Medicaid Oversight
DATE:	April 14, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Favorable**
2.	Barr	McKnight	AHS	**Pre-meeting**
3.			AP	

I. Summary:

SB 1060 establishes the Joint Legislative Committee on Medicaid Oversight within the Office of the Auditor General 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 authorizes the committee chair to create subcommittees and 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 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 requires the Auditor General and the Agency for Health Care Administration (AHCA) to enter into and maintain a data-sharing agreement by July 1, 2025. The bill requires the Auditor General to assist the committee in its work. The bill also 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.

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.

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.

The bill will have an indeterminate impact on state expenditures. See Section V., Fiscal Impact Statement.

The bill takes effect upon becoming a law.

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.[1] Joint legislative committees and other joint units of the Legislature are governed by joint rules of the Senate and the House of Representatives.[2]

The 2024-2026 Joint Rules of the Florida Legislature

The Joint Rules of the Florida Legislature, previously adopted in November 2024, address the following subjects:[3]

- JOINT RULE ONE – Lobbyist Registration and Compensation Reporting
- JOINT RULE TWO – General Appropriations Review Period and Budget Conference Committee Rules
- JOINT RULE THREE – Joint Offices and Policies
- JOINT RULE FOUR – Joint Committees
- JOINT RULE FIVE – Auditor General
- JOINT RULE SIX – Joint Legislative Budget Commission
- JOINT RULE SEVEN – Qualifications of Members
- JOINT RULE EIGHT – Adjourning and Reconvening of Each House of the Legislature and Providing for Adjournment Sine Die

JOINT RULE FOUR – Joint Committees

Joint Rule Four establishes the following standing joint committees:[4]

- The Joint Administrative Procedures Committee (JAPC);[5]
- The Joint Committee on Public Counsel Oversight;[6] and

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[1] The Florida Senate, *Glossary*, *available at* https://www.flsenate.gov/reference/glossary (last visited Mar. 16, 2025).
[2] Section 11.147(2), F.S.
[3] SCR 2 ORG (2024), enrolled.
[4] *Id*.
[5] The primary function of the JAPC is to generally review agency action pursuant to the operation of the Florida Administrative Procedure Act, particularly as these actions relate to the rulemaking process.
Florida Administrative Law Central Online Network, *About the Joint Administrative Procedures Committee, available at* https://www.japc.state.fl.us/Pages/About.aspx (last visited Mar. 15, 2025).
[6] The Joint Committee on Public Counsel Oversight appoints a Public Counsel, pursuant to s. 350.061, F.S. The committee may file a complaint with the Commission on Ethics alleging a violation of ch. 350, F.S., by a current or former public

- The Joint Legislative Auditing Committee (JLAC).[7]

The rule requires that no other joint committee may exist except as agreed to by the presiding officers or by concurrent resolution approved by the Senate and the House of Representatives. The rule also requires that each standing joint committee appoint no fewer than five and no more than seven members from each house.[8]

The rule establishes procedures for the appointment of the chair and vice chair of the standing joint committees and procedures for joint committees other than conference committees. The rule also establishes the powers and administration of joint committees.[9]

JOINT RULE FIVE – Auditor General

Joint Rule Five provides rulemaking authority to the Auditor General and requires the Auditor General to prepare and submit a proposed budget for the ensuing fiscal year annually to the President of the Senate and the Speaker of the House of Representatives for joint approval. The rule has provisions related to the salaries and expenses of the Auditor General. The rule also requires the Auditor General to distribute copies of each audit report to certain state officers, including the Governor; the Chief Financial Officer; the officer or person in charge of the state agency or political subdivision audited; the board of county commissioners of the county in which the audit was made, if applicable; each member of the JLAC; appropriate substantive and fiscal committees of the Senate and House of Representatives; and any other person who, in the opinion of the Auditor General, is directly interested in the audit or who has a connected duty to perform.[10]

The Auditor General

Florida's Auditor General is a constitutional and legislative officer, a certified public accountant, and the state's independent auditor 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.[11]

The Constitution of the State of Florida requires the Legislature to appoint an auditor to audit public records and perform related duties as prescribed by law or concurrent resolution. Section 11.42, F.S., designates the constitutional auditor as the Auditor General, and

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service commissioner, an employee of the Public Service Commission, or a member of the Public Service Commission Nominating Council. [SCR 2 ORG (2024), enrolled.]

[7] In general, the responsibilities of the JLAC are broad and affect all areas of government in the state. For instance, the JLAC may direct the Auditor General or the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct an audit, review, or examination of any entity or record as specified in s. 11.45(3), F.S. The JLAC is responsible for appointing the Auditor General, pursuant to s. 11.42(2), F.S., when there is a vacancy in the position.
The Florida Legislature, Online Sunshine, *Joint Legislative Auditing Committee, available at* http://www.leg.state.fl.us/cgi-bin/View_Page.pl?File=about.cfm&Directory=committees/joint/Jcla/&Tab=committees (last visited Mar. 15, 2025).

[8] SCR 2 ORG (2024), enrolled.

[9] *Id*.

[10] *Id*.

[11] Florida Auditor General, *About the Florida Auditor General, available at* https://flauditor.gov/pages/aboutus.html#tab (last visited Mar. 16, 2025).

ss. 11.42, 11.45, and 11.47, F.S., establish the general authority and duties. Independently, and in accordance with applicable professional standards, the Auditor General:

- Conducts financial audits of the accounts and records of state government, state universities, state colleges, and school districts.
- Conducts operational and performance audits of public programs, activities, and functions, as well as information technology systems.
- Adopts rules, in consultation with the Florida Board of Accountancy, for audits performed by independent certified public accountants of local governmental entities, charter schools and technical career centers, school districts, and certain nonprofit and for-profit organizations.
- Conducts reviews of audit reports of local governmental entities, charter schools and technical career centers, school districts, and certain nonprofit and for-profit organizations.
- Conducts examinations of school district records to evaluate compliance with state requirements governing the Florida Education Finance Program student enrollment and student transportation funding allocations.
- Conducts quality assessment reviews of the internal audits performed by state agency offices of inspector general. [12]

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[13] The federal Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for administering the Medicaid program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the Agency for Health Care (AHCA) and financed through state and federal funds.[14]

Statewide Medicaid Managed Care

Approximately 80 percent of Florida Medicaid recipients receive services through a plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and Dental. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.[15]

The AHCA awarded contracts to the current SMMC managed care plans through a competitive procurement process called an Invitation to Negotiate. The AHCA awarded and executed new contracts for SMMC 3.0 in October 2024, and officially rolled out the new SMMC 3.0 program on February 1, 2025. The rate year for the SMMC contracts is October 1 through September 30 of each contract year.[16]

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[12] Florida Auditor General, *About the Florida Auditor General, available at* https://flauditor.gov/pages/aboutus.html#tab (last visited Mar. 16, 2025).
[13] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Mar. 16, 2025).
[14] Section 20.42, F.S.
[15] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[16] *Id*.

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

- Hospital services;
- Physician services;
- Pharmacy services;
- Behavioral health services;
- Transportation to medical services;
- Nursing facility services; and
- Other service benefits, including, but not limited to, medical equipment and supplies, therapies, and home health services.[17]

The AHCA contracts with LTC plans in each region to provide LTC services, including all home and community-based waiver services, through their provider networks. Currently, all of the LTC plans contracted with the AHCA are also contracted to provide MMA services, streamlining care with a more comprehensive enrollment approach where a Medicaid recipient can enroll with one plan for all services.[18]

Managed care plans are considered "at-risk" because they are required to pay for the medically necessary services their members require, regardless of whether the capitation rates are sufficient to cover those costs. For instance, since the AHCA pays a fixed price per-member per-month PMPM capitation rate that covers all (or nearly all) the services a plan provides, if the plan spends more than it is paid, the plan loses money; however, if the plan needs to spend less than it is paid and still fulfills its contract with the AHCA and provides the services it's supposed to provide, then the plan makes money.[19]

Achieved Savings Rebate

Pursuant to s. 409.967(3), F.S., the AHCA implemented the Achieved Savings Rebate (ASR) Program as an incentive for proper use of state funds. The program monitors the premium revenues, medical and administrative costs, and income or losses for each plan. The ASR allows plans to retain a profit margin specified in statute; however, if the profit margin exceeds the limits specified in statute, plans must share a portion of the profits with the state or return the entire dollar amount beyond a certain threshold to the state.

The detailed financial reports for each plan are audited by an independent public accountant. The AHCA has program rules to ensure the independence of the public accountant and to establish criteria for the independent auditor.[20] The plans are responsible for paying the audit expenses incurred by the AHCA and, as part of the audit process, must provide all books, accounts,

[17] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[18] *Id*.
[19] *Id*.
[20] Office of Program Policy Analysis & Government Accountability, *Report No. 16-03, AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments* (Feb. 2016), *available at* https://oppaga.fl.gov/Documents/Reports/16-03.pdf (last visited Mar. 16, 2025).

documents, files, and information pertaining to Medicaid transactions to the AHCA and the contracted certified public accounting firm.[21]

The ASR is established by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:[22]

- 100 percent of income up to and including five percent of revenue shall be retained by the plan.
- 50 percent of income above five percent and up to 10 percent shall be retained by the plan, and the other 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.
- 100 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.

The program is tied to plan performance; if a plan exceeds the AHCA-defined quality measures in the reporting period, it may retain an additional one percent of revenue.[23]

The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:[24]

- Payment of achieved savings rebates.
- Any financial incentive payments made to the plan outside of the capitation rate.
- Any financial disincentive payments levied by the state or federal government.
- Expenses associated with any lobbying or political activities.
- 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.
- Reserves and reserve accounts.
- 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 AHCA.

Plans that incur a loss in the first contract year may apply the full amount of the loss as an offset to income in the second contract year.[25]

If, after an audit, the AHCA determines that a plan owes an additional rebate, the plan has 30 days after notification to make the payment. Upon failure to timely pay the rebate, the AHCA will withhold future payments to the plan until the entire amount is recouped. If the AHCA

[21] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[22] Section 409.967(3), F.S.
[23] *Id*.
[24] *Id*.
[25] *Id*.

determines that a plan has made an overpayment, the AHCA will return the overpayment within 30 days.[26]

Fee-for-Service and Managed Care Capitation Payments

In the state of Forida, Medicaid services can be delivered through a fee-for-service (FFS) or managed care delivery model. In FFS, providers contract directly with the AHCA to provide services, followed by billing and receiving direct reimbursement from the AHCA. In a managed care delivery model, managed care plans contract with the AHCA and are paid a per-member, per-month (PMPM) capitation rate for each plan enrollee to provide medical, dental, or home and community-based care, depending on the type of managed care plan. Providers contract with the managed care plans and bill the plans for services rendered to enrollees.[27]

The AHCA maintains provider fee schedules, which include the rates the AHCA pays FFS providers for services. However, in managed care, the managed care plans negotiate mutually agreed-upon rates with contracted providers for most services. The capitation rates reflect historical utilization and spending for covered services projected forward, and the PMPM capitation rate is paid to each plan each month regardless of the actual expenditure or level of claims of an individual enrollee. Currently, managed care plan capitation rates are both calculated and certified as actuarially sound by the AHCA's actuarial services vendor;[28] however, in the past, the AHCA conducted rate setting in-house and the certification was performed independently.[29]

Florida's Medicaid capitation rate-setting process is guided by standards and regulations set by the federal CMS. Actuaries must adhere to multiple standards and codes of conduct, including:[30]

- All federal requirements related to Medicaid;
- The federal CMS Medicaid Managed Care Rate Development Guide;[31]
- The American Academy of Actuaries (AAA) Actuarial Standards of Practice (ASOPs);[32] and
- The AAA[33] and Society of Actuaries Code of Conduct.[34]

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[26] Section 409.967(3), F.S.
[27] Florida Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[28] *Id*.
[29] The Florida Senate, *Issue Brief 211-226, Medicaid Managed Care Rate-Setting* (November 2010), *available at* https://www.flsenate.gov/UserContent/Session/2011/Publications/InterimReports/pdf/2011-226hr.pdf (last visited Mar. 16, 2025).
[30] *Supra* note 27.
[31] The Federal CMS Medicaid Managed Care Rate Development Guide outlines the necessary documentation required for the federal CMS review and approval of capitation rates.
U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *2024-25 Medicaid Managed Care Rate Development Guide, available at* https://www.medicaid.gov/medicaid/managed-care/downloads/2024-2025-medicaid-rate-guide-01222024.pdf (last visited Mar. 16, 2025).
[32] Standard 49 of the ASOPs, Medicaid Managed Care Capitation Rate Development and Certification, provides detailed guidance for setting Medicaid managed care capitation rates.
American Academy of Actuaries, Actuarial Standards Board, *All Standards, available at* https://www.actuarialstandardsboard.org/standards-of-practice/ (last visited Mar. 16, 2025).
[33] American Academy of Actuaries, *Code of Professional Conduct, available at* https://www.actuary.org/content/code-professional-conduct (last visited Mar. 16, 2025).
[34] Society of Actuaries, *Code of Professional Conduct, available at* https://www.soa.org/about/governance/about-code-of-professional-conduct/ (last visited Mar. 16, 2025).

To ensure full compliance with these standards and regulations, a comprehensive appendix is included in all final rate setting reports to address each relevant item of the federal CMS Medicaid Managed Care Rate Development Guide. Each rate submission is accompanied by an actuarial certification that verifies the accuracy and regulatory adherence of the rates. Additionally, all capitation rates undergo a thorough review by the federal CMS, involving multiple rounds of question and answers to validate the methodology utilized to develop rates for the approval.[35]

The AHCA's actuarial services vendor is Milliman Inc. (Milliman), and using encounter data in conjunction with financial data reported by the plans, Milliman develops capitation rates through the following steps:[36]

- Establishes the base data set using historical utilization and cost data;
- Adjusts the base data for any program changes, fee schedule increases, or legislative directives;
- Applies utilization, trend, seasonality, and acuity adjustments to reflect the new or current rating period; and
- Builds in managed care plan administrative costs and profit margins.

Capitation rates are risk-adjusted monthly for LTC and quarterly for MMA, but once the rates are set on October 1, they generally remain constant throughout the rate year unless a generational event or a material mistake requires a technical correction.[37]

Legislative increases to facility rates or provider fee schedules are built into the capitation rates for the health plans to pass-through to the providers during the following state fiscal year. Administrative expenses and increases to administrative expenses as a result of programmatic changes are built into the capitation rates as well, along with a two-percent profit margin for the plans, which may be more or less depending on the health of a plan's membership.[38]

The total capitated amount the health plans are paid is used to forecast the Medicaid budget for the following state fiscal year. At the Social Services Estimating Conference (SSEC),[39,40] managed care expenditures are combined with FFS expenditures and other appropriations to arrive at a total program cost, which is then trended forward to estimate the budgetary need for the coming state fiscal year.[41]

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[35] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[36] *Id*.
[37] *Id*.
[38] *Id*.
[39] The SSEC is a conference body consisting of members of the Legislature, representatives from the Governor's Office, and designees from various state agencies, which meets to develop Medicaid caseload or workload data and revenue/expenditure projections as it relates to TANF/WAGES, Medicaid, and Kidcare to assist in the budgeting and appropriations process. Florida Office of Economic & Demographic Research, *Consensus Estimating Conference Process, available at* https://edr.state.fl.us/Content/conferences/confprocess.pdf (last visited Mar. 16, 2025).
[40] The Florida Senate, *Glossary, available at* https://www.flsenate.gov/reference/glossary (last visited Mar. 16, 2025).
[41] *Supra* note 35.

As part of the rate-setting process, Milliman and the AHCA meet with the managed care plans to share base data and assumptions on costs of upcoming Medicaid program changes and potential changes and trends to the cost of the health care delivery system in general. Draft rates are developed during and shortly after each legislative session and most legislative changes are incorporated into the draft rates. After the legislative session, Milliman and the AHCA meet with the plans again to share and discuss the draft rates, and the plans are given an opportunity to provide feedback before the rates are finalized. Managed care plan feedback, post-legislative session changes to the General Appropriations Act, and additional months of experiential data can result in minor changes to the final rates when compared to the draft rates.[42]

Managed Care Plan Accreditation

Accreditation is a "seal of approval" given to a plan by an independent organization that evaluates the practices and performances of the plan. Accreditation indicates the plan meets specific quality standards. Accreditation status is one of the quality selection criteria the AHCA considers in the selection of eligible plans. Section 409.967(f)(3), F.S., requires each plan to be accredited by the National Committee for Quality Assurance (NCQA),[43] the Joint Commission,[44] or another nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract is executed. Each accrediting organization assesses plan performance against applicable standards and elements and establishes quality and performance standards, including, but not limited to, provider credentialing, prior authorization of services, and prompt payment of provider claims.[45]

SMMC Plan Provider Networks

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

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[42] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).

[43] The NCQA Health Plan Accreditation provides a current, rigorous, and comprehensive framework for essential quality improvement and measurement. Organizations use the NCQA to perform a gap analysis and align improvement activities with areas that are most important to states and employers, such as network adequacy and consumer protection. Standards evaluate plans on quality management and improvement, population health management, network management, utilization management, credentialing and recredentialing, members' rights and responsibilities, member connections, and Medicaid benefits and services. The use of Healthcare Effectiveness Data and Information Set (HEDIS) data focuses attention on activities that keep members healthy.
National Committee for Quality Assurance, *Health Plan Accreditation, available at* https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/ (last visited Mar. 16, 2025).

[44] Accreditation by the Joint Commission is the objective evaluation process helping health care organizations measure, assess, and improve performance to provide safe, high-quality care to patients. Accreditation is awarded upon successful completion of an on-site survey. The on-site survey is conducted by a specially trained Joint Commission surveyor, or team of surveyors, who assess the organization's compliance with the Joint Commission standards. During the survey, surveyors select patients randomly and use medical records as a roadmap to evaluate standards compliance. As surveyors trace a patient's experience in a health care organization, they speak to doctors, nurses, and other staff who interacted with the patient. Surveyors also observe doctors and nurses providing care and often speak to the patients themselves. All regular Joint Commission accreditation surveys are unannounced. Accreditation for most types of organizations is a three-year award. The exception is laboratory accreditation, which is a two-year award.
The Joint Commission, *What is Accreditation, available at* https://www.jointcommission.org/what-we-offer/accreditation/become-accredited/what-is-accreditation/ (last visited Mar. 16, 2025).

[45] *Supra* note 42.

service is accessible and provided with reasonable promptness. If the managed care plan declines to include individual or group providers in its provider network, the plan is required to give written notice to the affected provider(s) of the reason for its decision.[46] Managed care plans conduct credentialing and recredentialing for network providers and offer onboarding activities for new providers joining their networks.[47]

The new SMMC 3.0 contracts include strict requirements for improving quality and incorporating value-based purchasing (VBP) in provider agreements. VBP is a reimbursement strategy that links provider payments to high-quality performance. This agreement holds the providers accountable for both the quality and cost of care rendered. VBP supports a holistic approach to care that addresses both mental and physical health needs. VBP promotes the use of innovative health care models, such as telehealth and patient-centered medical homes, enhancing accessibility and coordination of care.[48]

Provider Credentialing Timeframes

Credentialing is the systematic process of verifying the qualifications of health care workers providing medical services. This important safety check ensures health care workers have the proper education, training, and licenses to care for patients, and reduces improper payments in Medicaid by minimizing the risk of unscrupulous providers billing the Medicaid program.[49]

To become a plan provider, the health care provider must obtain a Medicaid identification number from the AHCA and complete the plan's credentialing process. The average time required for a provider to obtain a Medicaid provider identification number from the AHCA is 61 days. The AHCA's contracts require the SMMC plans to fully enroll or on-board providers it chooses to contract with within 60 days of the provider submitting a complete application to the plan. Plans that fail to meet provider credentialing requirements could pay up to $5,000 per occurrence to the AHCA in liquidated damages.[50]

Both federal regulations[51] and state law[52] require each plan to have a system for verification and examination of the credentials of each of its providers. The same is true for plan accrediting bodies; however, no timeliness standard exists for the credentialing of plan providers.[53]

As part of the AHCA's federally required redesign of the Florida Medicaid Management Information System (FLMMIS), the AHCA contracted with an NCQA-certified vendor for its Provider Services Module to handle all aspects of the provider credentialing process, including those currently performed by the plans. The Provider Services Module will combine the Medicaid provider enrollment and plan credentialing processes into a single source to minimize

[46] 42 C.F.R. § 438.12(a)(1)
[47] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[48] *Id*.
[49] *Id*.
[50] *Id*.
[51] 42 C.F.R. § 438.214
[52] See Part IV of ch. 409, F.S., and s. 641.495(6), F.S.
[53] *Supra* note 47.

errors and confusion in the provider community. Transitioning providers from the current FLMMIS to the new Provider Services Module is scheduled to begin in fall of 2025.[54]

Prior Authorization Timeframes

Prior authorization is part of the overall utilization management program for a plan, which serves to identify patterns of over-utilization and under-utilization of services, identifying fraud, waste, and abuse. Prior authorization is a decision-making process conducted by a plan to determine whether a health care service or good is medically necessary before it is rendered. Not all Medicaid services require prior authorization. Federal regulations[55] require Medicaid managed care plans to conduct a prior authorization program that complies with the requirements of s. 1927(d)(5) of the Social Security Act. State Medicaid programs and contracted plans have the discretion to determine which services require prior authorization. Prior authorization processes are most often required for costly services and for services subject to a high-risk of fraud, waste, or abuse; however, plans are prohibited from requiring authorization for emergency services.[56]

Federal regulations[57] require Medicaid managed care plans to provide standard authorization decisions within 14 calendar days following receipt of the request for service. An additional 14 calendar day extension is available upon request of the enrollee or provider, or if the plan justifies a need for additional information and how the extension is in the enrollee's interest. The AHCA reduced this timeframe by negotiating a standard authorization timeframe of seven days with an extension period of four additional days, if necessary, reducing the authorization period from a maximum of 28 days to 11 days.

Federal regulations[58] also require Medicaid managed care plans to provide expedited authorization decisions within 72 hours following receipt of the request for service; an additional 14 calendar day extension remains available, if applicable. The AHCA further reduced this timeframe by negotiating an expedited authorization timeframe of two days with an extension period of one additional day, reducing the authorization period from a maximum of 17 days to three days.[59]

The AHCA currently requires plans to report monthly on all service authorization requests completed during the previous reporting month. Service authorizations are identified in one of four categories: standard authorization, extended standard authorization, expedited authorization, or extended expedited authorization. Plans that fail to meet provider credentialing requirements could pay up to $2,500 per occurrence to the AHCA in liquidated damages.[60]

[54] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[55] 42 C.F.R. § 438.3(s)(6)
[56] *Supra* note 54.
[57] 42 C.F.R. § 438.210(d)
[58] *Id*.
[59] *Supra* note 54.
[60] *Id*.

Prompt Payment Timeframes

Federal Medicaid law[61] sets requirements for timely claims payment to providers and defines a "claim" to mean a bill for services, a line item of service, or all services for one beneficiary within a bill. It also defines a "clean claim" to mean one that can be processed without obtaining additional information from the provider of the service or from a third-party. A clean claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.[62]

To receive timely payment, a provider must submit a clean claim that includes multiple, mandatory pieces of information about the patient and medical service. A claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system can be rejected. If all minimum edits pass and the claim is accepted, it will be entered into the system for processing. A denial is a claim that has passed minimum edits and is entered into the system but has been billed with invalid or inappropriate information causing the claim to be denied. There are hundreds of legitimate reasons a plan could and should deny payment for a health care service, all of which are standardized across the industry in the X12 Claim Adjustment Reason Code set,[63] referenced in the Health Care Claim Payment/Advice (835) Consolidated Guide, available from the Washington Publishing Company.[64]

Federal regulations[65] require state Medicaid programs to pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. States must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. States must pay all other claims within 12 months of the date of receipt, except in certain circumstances that allow the states to have additional time.[66]

Section 409.966(3)(c)6., F.S., requires SMMC plans to have a claims payment process that ensures claims that are not contested or denied will be promptly paid pursuant to s. 641.3155, F.S. Section 641.3155(3), F.S., specifies electronic claims payment standards and requires the plan to pay the claim or notify a provider if the claim is denied or contested within 20 days after receipt of the claim. If required, a provider must submit additional information and documentation as requested by the plan within 35 days after receipt of the plan notification. The claim must be paid or denied within 90 days of receipt of the claim. If the plan neither pays nor denies the electronic claim within 120 days, the plan is then obligated to pay the claim.[67]

For non-electronically submitted claims, a plan must pay the claim or notify a provider if the claim is denied or contested within 40 days after receipt of the claim. If required, a provider must submit additional information and documentation as requested by the plan within 35 days after

[61] 42 C.F.R. § 447.45
[62] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[63] X12, *External Code Lists, Claim Adjustment Reason Codes, available at* https://x12.org/codes/claim-adjustment-reason-codes (last visited Mar. 16, 2025).
[64] *Supra* note 62.
[65] *Supra* note 61.
[66] *Supra* note 62.
[67] *Id*.

receipt of the plan notification. The claim must be paid or denied within 90 days of receipt of the claim. If the plan has not paid or denied the nonelectronic claim within 120 days, the plan is then obligated to pay the claim within 140 days.[68]

As with the provider credentialing and prior authorization standards, the AHCA further reduced the claims payment timeframes by negotiating more stringent claims payment standards for the 2025-2030 SMMC contracts. Pursuant to the contracts, a plan must pay or notify the provider that the claim is denied or contested within 10 business days of receipt of nursing facility and hospice clean claims and within 15 days after receipt of all other claims. If the claim is denied or contested, the claim must be paid or denied within 90 days after receipt of the claim. If the plan neither pays nor denies the electronic claim within 120 days, the plan is then obligated to pay the claim. For non-electronically submitted claims, the plan must pay the paper claim or notify the provider that the claim is denied or contested within 20 days after receipt of the claim. If the plan neither pays nor denies the non-electronic claim within 140 days, the plan is then obligated to pay the claim.[69]

Additionally, the AHCA applies the following timely claims processing standards, which if not met, could result in a plan compliance action from the AHCA:[70]

- The managed care plan must pay 85 percent of all clean claims submitted within seven days.
- The managed care plan must pay 95 percent of all clean claims submitted within 10 days.
- The managed care plan must pay 98 percent of all clean claims submitted within 20 days.

Plans that fail to comply with claims processing requirements could pay up to $10,000 per month to the AHCA in liquidated damages for each month the AHCA determines the managed care plan is not in compliance.[71]

Managed Care Plan Complaints

The AHCA has a centralized complaint operations center to resolve Medicaid complaints timely and to determine if plans are complying with contract terms. All complaints are captured, whether substantiated or not, and the AHCA collects, aggregates, and trends the data for quality improvement initiatives.[72]

Federal laws and rules governing the Medicaid managed care plans do not define enrollee complaints. Instead, the AHCA has distinguished between "complaint" and "grievance" in the SMMC plan contracts, which are reviewed and approved by the federal CMS. Federal regulation[73] defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination.[74]

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[68] Florida Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[69] *Id*.
[70] *Id*.
[71] *Id*.
[72] *Id*.
[73] 42 C.F.R. § 438.400(b)
[74] *Supra* note 68.

For purposes of the SMMC program, the AHCA's contracts with the plans define a "complaint" as any oral or written expression of dissatisfaction by an enrollee submitted to the managed care plan or to a state agency and resolved by close of business the following business day. A complaint is a subcomponent of the grievance and appeal system. A complaint that is not resolved timely by close of business the following day becomes a grievance, for which the plan must provide the enrollee with a written notice of resolution within 90 days from receipt of the grievance. This process of escalation can continue from grievance to plan appeal, from plan appeal to Medicaid fair hearing, from Medicaid fair hearing to District Court of Appeals (DCA), and from DCA to the Florida Supreme Court. Each of these processes includes maximum timeframes mandated by the Code of Federal Regulations.[75]

Consistent with federal law, s. 409.967(2)(h), F.S., requires that each plan establish an internal process for reviewing and responding to grievances from enrollees. Each plan submits quarterly reports to the AHCA on the number, description, and outcome of grievances filed by enrollees. Plans that do not comply with grievance and appeal requirements could pay between $250 and $10,000 per occurrence to the AHCA in liquidated damages depending on the contract requirement the plan was out of compliance with.[76]

External Quality Review Organization

Federal regulations[77] require states to contract with a qualified external quality review organization (EQRO) to perform an annual, independent assessment of each managed care organization with which the state contracts. To conduct this assessment, the EQRO conducts activities consistent with the associated external quality review protocols developed by the federal CMS. The purpose of these activities, in general, is to improve the state's ability to oversee and manage plans they contract with for services and help plans improve their performance with respect to quality, timeliness, and access to care. Activities conducted by the EQRO each year are as follows:[78]

- Review of compliance, determining the extent to which plans comply with federal managed care regulations and state standards.
- Validation of performance measures, monitoring the performance of individual plans to track performance over time and to compare performance among the plans.
- Validation of performance improvement projects (PIPs), assessing the validity and reliability of PIPs.
- Validation of network adequacy, ensuring health plans maintain sufficient provider networks to provide adequate access to covered services for all enrollees.

Each April, the AHCA must submit the Annual Technical Report (ATR)[79] produced by the EQRO to the federal CMS and publish the report on the AHCA's external website. The ATR is a comprehensive report that describes the collection and analysis of data from all external quality

[75] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[76] *Id*.
[77] 42 C.F.R. § 438.358
[78] *Supra* note 75.
[79] Florida Agency for Health Care Administration, *SFY 2022-23 External Quality Review Technical Report* (April 2024), *available at* https://ahca.myflorida.com/content/download/24499/file/FL_2022-2023_EQR-TR_Report_F1.pdf (last visited Mar. 16, 2025).

review activities, as well as provides conclusions drawn related to the quality, timeliness, and access to care provided by the plans. Another element in the ATR is an assessment of the degree to which each plan has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's external quality review activities. The federal CMS reviews the EQRO's recommendations, including the ATR's overall compliance with federally required elements, and provides the state with its findings.[80]

Healthcare Effectiveness Data and Information Set Measures

By July 1 of each year, Medicaid health plans are required to report to the AHCA a number of Healthcare Effectiveness Data and Information Set (HEDIS) measures, and Medicaid and CHIP Core Sets of Health Care Quality measures (the Child and Adult Core Set measures). HEDIS measures are developed and validated by the NCQA and used by over 90 percent of managed care plans in the nation to track their performance. The federal CMS requires states to report the Child Core Set and Adult Behavioral Health Core Set measures to the federal CMS on an annual basis. Many of the core set measures are HEDIS measures but there are also non-HEDIS measures in the core sets.[81]

Plans report HEDIS data based on the services enrollees received in the previous calendar year (e.g., performance measure data reported on July 1, 2025, represents calendar year 2024 services). The AHCA requires the plans to use NCQA-certified software vendors for running and calculating performance measures and requires the plans to have performance measures reviewed and certified by NCQA-certified HEDIS auditors prior to submitting performance measure results to the AHCA. Examples of required performance measures are well-child visits, immunizations, mammograms and other cancer screenings, pregnancy-related care, mental and behavioral health care, and diabetes care. The performance measure data provided by the plans are reviewed by the AHCA's staff and validated by the AHCA's EQRO. The AHCA compares performance measure data to national benchmarks to calculate performance measure liquidated damages and create the Florida Medicaid Health Plan Report Card.[82,83]

The AHCA compares plan performance on performance measures to benchmarks that are set in the plan contracts and plans may be assessed liquidated damages for measures where performance is worse than the benchmarks. When assessed liquidated damages, plans are required to pay the AHCA within 30 days after receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. Plans may dispute the imposition of liquidated damages by requesting that the AHCA's Deputy Secretary for Medicaid or designee hear and decide the dispute.[84]

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[80] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[81] *Id*.
[82] The Florida Medicaid Health Plan Report Card is a tool that enrollees can use when comparing and choosing plans based on quality of care. Plans are compared using a five-star rating scale in five categories: Pregnancy-related Care, Keeping Kids Healthy, Keeping Adults Healthy, Living with Illness, and Behavioral Health Care.
Agency for Health Care Administration, Health Care Transparency, *Quality of Care Indicators – Ratings, Medicaid Health Plan Report Cards, available at* https://quality.healthfinder.fl.gov/Facility-Provider/Medicaid-ReportCard?&type=-13 (last visited Mar. 16, 2025).
[83] *Supra* note 80.
[84] *Id*.

Under the 2025-2030 SMMC contracts, the AHCA established a new quality continuum of incentives and accountability based on performance measure results. There is a quality withhold that plans may earn back based on their performance on specified performance measures, as well as a Quality Bonus Pool, built with the funds from plans that have not earned their full withhold back. Plans that earn their whole withhold may also earn funds from the Quality Bonus Pool, and the top plans may earn a quality preferred assignment incentive. The highest performing plans may qualify for the Achieved Savings Rebate one percent quality incentive. The plans that do not meet specific benchmarks set in the contract may be assessed for liquidated damages or sanctions.[85]

Performance Improvement Projects

In accordance with federal law[86] and as part of a comprehensive quality assessment and performance improvement program, states must require managed care plans to implement performance improvement projects (PIPs). The purpose of these projects is to achieve significant improvement in measurement of quality performance with objective indicators, as well as to generally sustain this improvement over time.[87]

States must[88] require plans to conduct clinical and nonclinical PIPs to examine access to and quality of care. PIPs must include four key elements:[89]

- Performance measurement;
- Implementation of interventions;
- Evaluation of the interventions' impact using the performance measures; and
- Activities to increase or sustain improvement.

Under the 2025-2030 SMMC contracts, the MMA plans are required to conduct PIPs focused on the following topics: promoting healthy birth outcomes for mothers and infants, improving child and adolescent mental health, Hope Florida, and closing gaps in health care outcomes between plan sub-populations. Plans providing specialty product lines are required to conduct an additional PIP focused on a clinical area in need of improvement for each specialty area. Plans providing LTC services are also required to conduct a PIP focused on improving mental health in adults and a PIP focused on maximizing home and community-based placement, as well as services to improve independence, well-being, and safety.[90]

Historically, the plans have submitted PIP documentation annually for the AHCA's review and validation by the EQRO. Under the 2025-2030 SMMC contracts, the AHCA is requiring the plans to submit quarterly progress reports on PIPs to allow for more frequent monitoring of the plans' progress toward reaching the goals identified in the PIPs.[91]

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[85] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[86] 42 C.F.R. § 438.330
[87] *Supra* note 85.
[88] *Supra* note 86.
[89] *Supra* note 85.
[90] *Id*.
[91] *Id*.

Plan Performance Dashboard

The AHCA maintains an extensive internal plan performance dashboard, which allows the AHCA to comprehensively track the performance of each plan on executing the terms of their contract. The AHCA first launched this dashboard in January 2020. The dashboard visualizes how the SMMC plans are performing and compares the performance of each plan across key performance areas, such as Potentially Preventable Events, Performance Measures, Provider Network Adequacy, Quality Indicators, Birth Outcomes, LTC Performance, Administrative and Financial, and Delivery System Performance. The AHCA posts a new dashboard every quarter for plans to review performance compared to their peers.[92]

Compliance Actions

The AHCA is responsible for imposing compliance actions as a result of plan failure to meet any aspect of the responsibilities of a contract and its exhibits. The three types of compliance actions that may be imposed include liquidated damages, sanctions, and/or corrective action plans. Liquidated damages are the lowest level of compliance actions and are considered non-punitive, as they reflect the projected financial loss or damage to the AHCA. Sanctions may be monetary or non-monetary (e.g., freeze in enrollment) and are issued for more egregious non-compliance issues. Corrective action plans are utilized when non-compliance rises to the level of immediate remediation and steps are put into place to ensure the non-compliance does not reoccur.[93]

Ongoing plan monitoring is a responsibility across all the AHCA's functional units. Functional units contain subject matter experts (SMEs) needed to monitor and improve plan or program performance. Monitoring is conducted through a variety of channels including review of reports, ad hoc requests, standard contract monitoring, and monitoring of complaints received by the AHCA.[94]

For the state fiscal year 2023-2024, the AHCA executed 354 compliance actions, which resulted in a total of approximately $33.8 million in liquidated damages paid by the plans.[95]

Medical Care Advisory Committee (MCAC)

Federal regulations[96] require each state Medicaid program to establish a committee to serve in an advisory capacity on health and medical care issues. The committee must include the following:[97]

- Board-certified physicians and other representatives of the health professions familiar with the medical needs of low-income people and the resources available for their care;
- Members of consumer groups, including Medicaid recipients; and
- Agency heads from the Department of Children and Families and the Florida Department of Health.

[92] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[93] *Id*.
[94] *Id*.
[95] *Id*.
[96] 42 C.F.R. § 431.12
[97] Florida Agency for Health Care Administration, *Medical Care Advisory Committee, available at* https://ahca.myflorida.com/medicaid/medical-care-advisory-committee (last visited Mar. 16, 2025).

The committee may be asked to provide the AHCA with advice on improving Medicaid recipients' access to specialists and enhancing communication with Medicaid recipients. Members may also be asked to review and provide input on a variety of Medicaid materials and to make recommendations to the AHCA about Medicaid policies, rules, and procedures.[98]

Medicaid Oversight Committees in Other States

Medicaid oversight committees similar to the committee created by the bill exist in the following states:

- Connecticut;[99]
- Illinois;[100]
- Indiana;[101]
- Iowa;[102]
- Louisiana;[103]

[98] *Id*.

[99] The Connecticut Council on Medical Assistance Program Oversight, referred to as the Medical Assistance Program Oversight Council (MAPOC), biannually reports to the General Assembly as required under state law. The Medical Assistance Program Oversight Council (previously called the Medicaid Managed Care Council) is a collaborative body established by the General Assembly in 1994 to initially advise the Connecticut Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program (HUSKY A). Legislation in 2011 revised state law to include council oversight of the Medicaid HUSKY Health Program that encompasses all Medicaid enrollees' health care. State statute charges the council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation of the new delivery system under Administrative Service Organizations (ASOs), transitional issues from managed care, eligibility standards, benefits, health care access, and quality measures. Connecticut General Assembly, *Council on Medical Assistance Program Oversight, available at* https://www.cga.ct.gov/ph/med/ (last visited Mar. 16, 2025).

[100] The Illinois Medicaid Managed Care Oversight Commission was created within the Illinois Department of Healthcare and Family Services (HFS) to evaluate the effectiveness of the Illinois managed care program. The HFS details the membership composition and the commission requirements.
Illinois Department of Healthcare and Family Services, *Medicaid Managed Care Oversight Commission, available at* https://hfs.illinois.gov/about/boardsandcommisions/medicaidmanagedcareoversightcommission.html (last visited Mar. 16, 2025).

[101] The Indiana Medicaid Oversight Committee was created to review, consider, and make recommendations concerning all requests for new services and changes in existing services for the state Medicaid program.
Indiana General Assembly, *Medicaid Oversight Committee, available at* https://iga.in.gov/2023/committees/interim/medicaid-oversight-committee (last visited Mar. 16, 2025).

[102] The Iowa Joint Health Policy Oversight Committee was established in 2015 to provide continuing oversight for Medicaid managed care, ensure effective and efficient administration of the program, address stakeholder concerns, monitor program costs and expenditures, and make recommendations to the General Assembly.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).
The Iowa Legislature, *Health Policy Oversight Committee (J), available at* https://www.legis.iowa.gov/committees/committee?groupID=24165&ga=91 (last visited Mar. 16, 2025).

[103] The Louisiana Joint Medicaid Oversight Committee was established in 2020 to improve oversight and teach appointed legislators the complexities of the program, which consists of nearly half of the state's budget. Duties of the committee are as follows: to monitor, review, and make recommendations; to review the compliance of the Louisiana Department of Health; and to plan, advertise, organize, and conduct forums, conferences, and other meetings in which representatives of state agencies, and other individuals with expertise in the state Medicaid program, may participate to increase knowledge and understanding of the state Medicaid program, as well as propose improvements. The committee can hold hearings, require the

- North Carolina;[104] and
- Ohio.[105]

III. Effect of Proposed Changes:

Section 1 creates s. 11.405, F.S., to establish the Joint Legislative Committee on Medicaid Oversight within the Office of the Auditor General, established under s. 11.42, F.S., 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 requires that the committee be composed of three members of the Senate appointed by the President of the Senate and three 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 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.

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production of books and records, and may call upon staff of any department, agency, or official of the state for data and assistance.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

[104] North Carolina's Joint Legislative Oversight Committee on Medicaid and NC Health Care is responsible for examining the budget, finance, administration, and operational issues related to the programs. The committee can gain access to any paper or document and may compel the attendance of any state official or employee before the committee or secure any evidence and issue subpoenas. The committee receives reports from the North Carolina Department of Health and Human Services (DHHS) throughout the session, and the DHHS is required to send a copy of any report to the General Assembly or committee to the co-chairs of the Medicaid Oversight Committee.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

[105] The Ohio General Assembly established the Joint Medicaid Oversight Committee in 2014 to continuously oversee the state's Medicaid program. The committee's responsibilities include ensuring Medicaid compliance aligns with legislative objectives, assessing the long-term effects of legislation on Medicaid, and aiding in controlling spending growth while enhancing the quality of care and health outcomes for Medicaid beneficiaries in the state. Apart from possessing subpoena power, the committee and its staff are authorized to conduct unannounced inspections of Medicaid offices within state and local governments. The committee requires regular reports from the Ohio Department of Medicaid on issues, including access barriers, program participation, and the needs of low-income pregnant women and children. The State Auditor provides reports to the committee upon request.
Levin Center for Oversight and Democracy, Levin Center Home, *New Series Oversight Overview: Medicaid Oversight Committees, available at* https://www.levin-center.org/introducing-oversight-overview-medicaid-oversight-committees/ (last visited Mar. 16, 2025).

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 Agency for Health Care Administration (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, 2025, 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 2 provides that the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

The bill creates statutory language to establish a joint legislative committee, which may bind future legislative bodies to the organization and structure proposed in this bill. The general rule of law[106] is that one legislature cannot bind to limit or enlarge the powers of a subsequent legislature or inhibit it from amending or repealing any legislation so long as it does not act contrary to or inconsistently with any constitutional limitations on the legislative power in any given case.[107]

The Florida Legislature has an absolute right to repeal or modify any statute, so long as its actions do not transgress constitutional requirements. Thus, the power of a future legislature cannot be limited by the acts of a present or prior legislature. In 2011, the Florida Legislature removed statutory language creating or directing joint legislative

[106] See *Nue v. Miami Herald Publishing Co.*, 462 So. 2d 821 (Fla. 1985); *Internal Improvement Fund v. St. Johns River Co.*, 16 Fla. 531 (Fla. 1878); *Gonzales v. Sullivan*, 16 Fla. 791 (Fla. 1878).
[107] State of Florida's Office of the Attorney General, *Postaudit Expenditures, Counties, available at* https://www.myfloridalegal.com/ag-opinions/postaudit-expenditures-counties (last visited Mar. 16, 2025).

committees and offices, allowing the current Legislature to assert direct administrative oversight through the adoption of joint rules.[108]

As such, a joint legislative committee enacted by SB 1060 might be able to exist only as part of the organizational structure of the current Legislature. At this time, the JAPC, the Joint Committee on Public Counsel Oversight, and the JLAC are Florida's only standing joint legislative committees, and Joint Rule 4.1 requires that no other joint committee exist except as agreed to by the presiding officers or by concurrent resolution approved by the Senate and the House of Representatives.[109]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill could result in an indeterminate fiscal impact on state expenditures. While member reimbursement for per diem and travel expenses, pursuant to s. 112.061, F.S., is nominal, the Office of the Auditor General, the Agency for Health Care Administration (AHCA), and the Statewide Medicaid Managed Care (SMMC) plans may experience an increased workload, impacting all entities administratively and/or operationally, potentially creating a need for additional staff and resources.

According to the AHCA, the function of the committee would result in the duplication of efforts already conducted by the AHCA, its contracted vendors, the Office of the Auditor General, the SMMC plans, and the federal Centers for Medicare & Medicaid Services.[110]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill creates the Joint Legislative Committee on Medicaid Oversight within the Office of the Auditor General. This may cause issues with the organizational structuring of the Legislature as it is unclear whether a joint legislative committee can be housed within a legislative entity, such as the Office of the Auditor General. As the Joint Legislative Auditing Committee (JLAC) has

[108] The Florida Senate, *Senate Bill 1204 Final Bill Analysis* (2011) (on file with Senate Committee on Health Policy).
[109] SCR 2 ORG (2024), enrolled.
[110] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).

the authority to appoint and direct the Auditor General, it would appear that the bill establishes that the committee would be servicing or supporting another joint legislative committee (JLAC).

As the Office of the Auditor General is responsible for auditing the Agency for Health Care Administration (AHCA) and the Medicaid program, the AHCA indicated a conflict of interest may exist in that the Auditor General would ultimately have oversight responsibilities, including the development of policy recommendations, of an entity that it independently audits. As independence rules for certified public accountants require the maintenance of independence in both fact and appearance, the Auditor General could be placed in a situation in which its independence is impaired or questioned with respect to the Medicaid program.[111]

Lines 110-115 of the bill establish applicability in 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. As such, the bill may benefit from an amendment for clarity as it requires committee membership consisting of three members of the Senate and three members of the House of Representatives; however, Joint Rule 4.1 requires no fewer than five and no more than seven members from each house be appointed to each standing joint committee.[112]

Joint Rule 4.1 also establishes a schedule or timeframe in which the chair and vice chair will serve. While the bill does provide for alternating chair and vice chair appointments between the President of the Senate and the Speaker of the House of Representatives similar to the Joint Rules of the Legislature, it remains unclear which house will appoint the chair or vice chair first and the language is inconsistent with that of other joint legislative committees, as indicated in Joint Rule 4.1.[113]

The AHCA expressed the bill may cause delays in Statewide Medicaid Managed Care rate setting that could impact the AHCA's ability to comply with federal Medicaid managed care laws.[114]

VIII. Statutes Affected:

This bill creates section 11.405 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.

[111] Agency for Health Care Administration, *Senate Bill 1060 Bill Analysis* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[112] SCR 2 ORG (2024), enrolled.
[113] *Id*.
[114] *Supra* note 111.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete lines 26 - 36
and insert:
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 "Legislative Committee on Medicaid Oversight"

509320

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

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

And the title is amended as follows:

Delete lines 2 - 5

and insert:

An act relating to Medicaid oversight; amending s. 1.01, F.S.; defining the term "Legislative Committee on Medicaid Oversight"; creating s. 11.405, F.S.; establishing the Joint Legislative Committee on Medicaid Oversight for specified purposes; providing

By Senator Brodeur

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A bill to be entitled

An act relating to Medicaid oversight; creating s. 11.405, F.S.; establishing the Joint Legislative Committee on Medicaid Oversight within the Office of the Auditor General 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; providing that the committee must 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; providing an effective date.

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

Section 1. 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

10-01068-25 20251060__

within the Office of the Auditor General established under s. 11.42 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 three members of the Senate appointed by the President of the Senate and three 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 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.

(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, financials, 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 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, 2025, 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 2. This act shall take effect upon becoming 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 Appropriations Committee on Health and Human Services

BILL:	CS/SB 1144
INTRODUCER:	Governmental Oversight and Accountability Committee and Senator Burgess
SUBJECT:	Hope Florida
DATE:	April 14, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harmsen	McVaney	GO	**Fav/CS**
2.	Sneed	McKnight	AHS	**Pre-meeting**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1144 codifies the Office of Hope Florida within the Executive Office of the Governor. The Hope Florida program uses Hope Navigators to coordinate services from both the public and private sectors to help Floridians achieve self-sufficiency, maximize community integration, and build a prosperous future.

The bill defines terms, provides participant eligibility requirements, and outlines the Office's and participating agencies' duties, including the operation of a toll-free "Hope Line," development and maintenance of the program's website, and creation of a case management system.

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

The bill takes effect upon becoming a law.

II. Present Situation:

Hope Florida – a Pathway to Prosperity, Economic Self-Sufficiency and Hope (Hope Florida) was established on September 9, 2021, by First Lady Casey DeSantis.[1] Hope Florida pairs Floridians who reach out to the program (the "client") with a care navigator. The navigator helps

[1] HopeFlorida, *Timeline*, https://hopeflorida.com/about-us/timeline.html (last visited Mar. 25, 2025).

identify the client's goals and pairs the client with resources from faith-based, non-profit, government, and private sector entities to reach those goals.[2]

Hope Florida was initially implemented by the Department of Children and Families (DCF) in a three-phase rollout, with services beginning in August 2020 in the state's northwest and central regions with 30 full-time care navigators; phase two expanded into the Northeast and Southeast regions in January 2021 with 65 full-time care navigators; phase three launched in July 2021 in the Suncoast and Southern regions with 102 full-time care navigators.[3]

Hope Florida has since grown to also include the:

- Hope Florida Fund (established July 15, 2022), which "harnesses the charity of the private sector to give funds to deserving local entities."[4]
- Activate Hope (established August 21, 2024), an emergency response entity that works with the Florida Division of Emergency Management to help Floridians who are recovering from disasters.[5]
- Hope Line – A toll-free hotline, "833-GET-HOPE."[6]
- Hope Florida – A Pathway to Potential program within the Department of Juvenile Justice and its 40 Hope Navigators, to support vulnerable youth.[7]
- Coordinated efforts between Hope Florida, CareerSource Florida and the DCF to help unemployed Floridians find jobs. This specific program received $4.3 million in state funds to fund Hope Navigators to work at all local workforce development boards and provide other related services.[8]
- Hope Florida – A Pathway to Purpose program within the Department of Elder Affairs (DOEA) to provide volunteer opportunities for and support to elderly Floridians. The DOEA established their own Hope Navigators to facilitate this program.[9]

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[2] *See*, Florida Department of Children and Families, *Hope Florida: A Pathway to Prosperity* at 2, https://www.homelesstrust.org/resources-homeless/library/providers/training/hope-florida.pdf (last visited Mar. 25, 2025).
[3] Early Learning Coalition of Miami-Dade/Monroe, *Introducing HOPE FLORIDA A Pathway to Prosperity* (Oct. 2021), https://www.elcmdm.org/Content/Uploads/elcmdm.org/files/Meeting%20Packages/Hope%20Florida%20PPT.pdf (last visited Mar. 25, 2025).
[4] Press Release, the Executive Office of the Governor, *First Lady Casey DeSantis Makes Major Announcements to Support the Hope Florida-a Pathway to Prosperity Initiative* (July 15, 2022), https://www.flgov.com/eog/news/press/2022/first-lady-casey-desantis-makes-major-announcements-support-hope-florida-pathway (last visited Mar. 25, 2026).
[5] Press Release, the Executive Office of the Governor, *Governor Ron DeSantis and First Lady Casey DeSantis Announce Emergency Response Hope Florida Expansion* (Aug. 21, 2024), https://flgov.com/eog/news/press/2024/governor-ron-desantis-and-first-lady-casey-desantis-announce-emergency-response (last visited Mar. 26, 2025).
[6] Hope Florida, *Get Help*, https://hopeflorida.com/get-help/ (last visited Mar. 26, 2025).
[7] Press Release, the Executive Office of the Governor, *First Lady Casey DeSantis Announces Hope Florida- A Pathway to Potential, Expanding the Hope Florida Model to Support At-Risk Youth and Their Families* (Mar. 29, 2023), https://flgov.com/eog/news/press/2024/first-lady-casey-desantis-announces-hope-florida-pathway-potential-expanding-hope (last visited Mar. 26, 2025).
[8] Press Release, the Executive Office of the Governor, *First Lady Casey DeSantis Announces Hope Florida to Help Floridians with Barriers to Employment Find Promising Careers* (Jun. 9, 2023), https://www.flgov.com/eog/news/press/2023/first-lady-casey-desantis-announces-hope-florida-help-floridians-barriers (last visited Mar. 26, 2025).
[9] Press Release, the Executive Office of the Governor, *First Lady Casey DeSantis Announces Hope Florida to Support Seniors Through 'A Pathway to Purpose*,' (Aug. 30, 2022), https://www.flgov.com/eog/news/press/2022/first-lady-casey-desantis-expands-hope-florida-support-seniors-through-pathway (last visited Mar. 26, 2025).

- Hope Florida – A Pathway to Promise within the Guardian ad Litem office and the DOEA to assist youth who age out of foster care.[10]
- Hope Florida – A Pathway for Patriots program within the Department of Veterans' Affairs to assist veterans navigate their benefits.[11]

In January 2025, the Hope Florida Office was established within the Executive Office of the Governor to oversee and administer Hope Florida.[12] The Hope Florida Office works with state agencies to "deepen partnerships with both public and private sectors."

III. Effect of Proposed Changes:

Office of Hope Florida Within the Executive Office of the Governor

The bill codifies the establishment of the Office of Hope Florida (Office) within the Executive Office of the Governor to align and coordinate state agency participation in the Hope Florida program. The Office's duties include:

- Establishing goals and strategies for Hope Florida;
- Facilitating coordination and collaboration among participating agencies to achieve the program's goals;
- Expanding the Hope Florida Partner Network to meet the needs of those served by the program;
- Developing and implementing care plans for program participants in partnership with Hope Navigators;
- Using participating state agencies and public-private partnerships to serve program participants and help them overcome barriers to self-sufficiency; and
- Overseeing the Hope Florida partner network, which is composed of designated state agencies, private-public partnerships, and nonprofit, private sector, and faith-based organizations that are actively engaged in Hope Florida and provide goods or services to directly support participants' goals and address identified barriers.

The bill grants the Governor authority to appoint a director of the Office who serves at the pleasure of the Governor.

Hope Navigators

The bill describes Hope Navigators as resources who "must be embedded within communities" and serve as a single point of contact for program participants. The Hope Navigators create care

[10] Press Release, the Executive Office of the Governor, *First Lady Casey DeSantis Announces Hope Florida- A Pathway to Promise, Expanding the Hope Florida Model to Support Youth Aging Out of Foster Care*, (Sept. 20, 2023), https://www.flgov.com/eog/news/press/2023/first-lady-casey-desantis-announces-hope-florida-pathway-promise-expanding-hope (last visited Mar. 26, 2025).
[11] Press Release, the Executive Office of the Governor, *First Lady Casey DeSantis Announces Hope Florida Initiative Expansion to Serve Florida Veterans* (Nov. 22, 2023), https://www.flgov.com/eog/news/press/2023/first-lady-casey-desantis-announces-hope-florida-initiative-expansion-serve-florida (last visited Mar. 26, 2025).
[12] Press Release, the Executive Office of the Governor, *Governor Ron DeSantis and First Lady Casey DeSantis Establish Hope Florida Office Within the Executive Office of the Governor* (Jan. 14, 2025), https://www.flgov.com/eog/news/press/2025/governor-ron-desantis-and-first-lady-casey-desantis-establish-hope-florida-office (last visited Mar. 26, 2025).

plans based on the information provided by the program participant to help connect the participant with community resources to help participants achieve their goals, overcome barriers, and realize their full potential. The bill also defines a Hope Navigator as an individual who coordinates care and assists participants and families seeking services through Hope Florida.

The bill defines a "care plan" as a written document that contains information provided by the Hope Florida program participant to develop and customize steps and timelines to achieve their goals. The care plan must include actionable steps and corresponding timelines to address immediate, intermediate, and long-term goals and barriers toward achieving self-sufficiency.

Agency Participation

The bill requires state agencies to participate in Hope Florida at the direction of the Executive Office of the Governor (EOG). However, the Department of Children and Families, Agency for Persons with Disabilities, Department of Juvenile Justice, Statewide Guardian ad Litem Office, Department of Education, Agency for Health Care Administration, Division of Emergency Management, Department of Veterans' Affairs, Department of Commerce, and the Department of Elder Affairs are required to participate without need for the Governor's direction.

Each agency must use its existing resources and personnel, to the extent possible, to operate Hope Florida.

The bill allows public-private partners, including CareerSource Florida and the Florida Commission on Community Service, to participate at the direction of the Hope Florida Office.

Participant Eligibility

Participation in Hope Florida is voluntary. Individuals may receive assistance by calling the Hope Line. To participates in Hope Florida, an individual must be:

- A Florida resident;
- A citizen or permanent resident alien of the United States; and
- At least 18 years of age, or, if emancipated, 16 years of age. However, an unemancipated minor may participate with his or her parent or guardian's consent.

Miscellaneous

The bill creates the "Hope Florida Act" in ss. 23.41-23.45, F.S.

The bill defines the terms:

- "Hope Florida partner network" as a group of entities, including state agencies, public-private partnerships, and nonprofit, private-sector, and faith-based organizations that provides goods or services directly support Hope Florida participants.
- "Hope Line" as a toll-free hotline for Hope Florida inquiries and referrals for individuals and families in need of services.
- "Office" as the Hope Florida Office within the EOG.
- "Participant" as an individual who voluntarily participates in Hope Florida.

- "Participating state agency" as a state agency participating in Hope Florida at the direction of the EOG.

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Not applicable. The bill does not require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

B. Public Records/Open Meetings Issues:

This bill is linked to SB 1146, which provides a public records exemption for the personal identifying information of a participant in the Hope Florida program.

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:

The Hope Florida program may make it easier for Floridians in need of services to become aware of public and private nonprofit organizations that may assist them.

C. Government Sector Impact:

The bill is expected to have an insignificant, negative fiscal impact on state expenditures, as agencies are required to utilize existing resources, where feasible, to carry out its provisions. Current staffing and resources within the Hope Florida Office and participating state agencies appear adequate to support continued program operations.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 23.41, 23.42, 23.43, 23.44, and 23.45.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Governmental Oversight and Accountability on April 1, 2025:

- Moves the program to chapter 23, regarding "miscellaneous executive functions" and provides a title for the act, the "Hope Florida Act;"
- Adds additional defined terms; and
- Provides a more narrow list of the state agencies that shall participate in the program at the direction of the Executive Office of the Governor.

B. Amendments:

None.

By the Committee on Governmental Oversight and Accountability; and Senator Burgess

585-03145-25 20251144c1

A bill to be entitled

An act relating to Hope Florida; creating part IV of ch. 23, F.S., entitled "Hope Florida"; creating s. 23.41, F.S.; providing a short title; creating s. 23.42, F.S.; providing the goals of Hope Florida; creating s. 23.43, F.S.; defining terms; creating s. 23.44, F.S.; creating the Hope Florida Office within the Executive Office of the Governor; requiring the Governor to appoint the director of the Hope Florida Office; providing that such director serves at the pleasure of the Governor; providing duties of the office; providing eligibility requirements for Hope Florida participants; specifying that participation in Hope Florida is voluntary; specifying mechanisms by which individuals may receive assistance; requiring the office to designate a state agency to perform certain functions; creating s. 23.45, F.S.; requiring that Hope Navigators be embedded in communities for specified purposes; requiring that care plans include certain steps and timelines; requiring the Hope Florida partner network to work to build a network of partnerships for a specified purpose; requiring specified state agencies to participate in Hope Florida at the direction of the Executive Office of the Governor; authorizing other entities to participate in Hope Florida at the direction of the office; providing an effective date.

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

Florida Senate - 2025 CS for SB 1144

585-03145-25 20251144c1

Section 1. Part IV of chapter 23, Florida Statutes, consisting of ss. 23.41, 23.42, 23.43, 23.44, and 23.45, is created and entitled "Hope Florida."

Section 2. Section 23.41, Florida Statutes, is created to read:

23.41 Short title.—This part may be cited as the "Hope Florida Act."

Section 3. Section 23.42, Florida Statutes, is created to read:

23.42 Hope Florida goals.—The goals of Hope Florida are to:

(1) Streamline access to support, services, and assistance so that residents in need can reach their full potential within their local communities and to holistically coordinate care through Hope Navigators.

(2) Facilitate alignment and coordination of participating state agencies.

(3) Break down traditional silos and establish a seamless network of support systems, managed through one centralized system comprised of private businesses, nonprofit entities, state agencies, and faith-based organizations, to effectively achieve desired outcomes and sustain long-term results including greater self-sufficiency, community integration, and the reduction of the participant's sole reliance on government programs.

Section 4. Section 23.43, Florida Statutes, is created to read:

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

(1) "Care plan" means a written document that contains

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

information provided by Hope Florida to its participants for whom Hope Florida has developed and customized actionable steps and corresponding timelines to assist the participants in achieving their immediate, intermediate, and long-term goals. The care plan must also address barriers by directly connecting participants to community resources and opportunities.

(2) "Hope Florida partner network" means a group of entities, including state agencies, public-private partnerships, and nonprofit, private-sector, and faith-based organizations, which is actively engaged in Hope Florida and which provides goods or services to directly support the participants' goals and address identified barriers.

(3) "Hope Line" means a statewide toll-free telephone number that serves as a hotline for Hope Florida inquiries and referrals for services.

(4) "Hope Navigators" means individuals who coordinate care and assist participants and families seeking services through Hope Florida.

(5) "Office" means the Hope Florida Office within the Executive Office of the Governor.

(6) "Participant" means an individual who voluntarily participates in Hope Florida.

(7) "Participating state agency" means a state agency participating in Hope Florida at the direction of the Executive Office of the Governor.

Section 5. Section 23.44, Florida Statutes, is created to read:

23.44 Hope Florida Office; eligibility to participate; duties.—

(1) The Hope Florida Office is created within the Executive Office of the Governor. The director of the Hope Florida Office is appointed by and serves at the pleasure of the Governor.

(2) The office shall:

(a) Establish goals and strategies for Hope Florida.

(b) Facilitate coordination and collaboration among participating state agencies to achieve these goals.

(c) Expand the Hope Florida partner network to meet the needs of participants.

(d) Empower and assist residents in need to help identify and achieve immediate, intermediate, and long-term goals and remove barriers to their personal goal achievement through the development and implementation of care plans in partnership with Hope Navigators.

(e) Use Hope Navigators to assist participants in identifying personal goals, developing individualized plans for achieving immediate, intermediate, and long-term goals, identifying and addressing barriers, and actively connecting participants to community resources and opportunities to achieve their goals.

(f) Use participating state agencies to serve families holistically in achieving self-sufficiency, maximizing community integration, and building a prosperous future. Barriers to self-sufficiency may include the inability to:

1. Obtain stable employment;

2. Increase wages;

3. Obtain the necessary skills for greater independence, education, or training;

4. Meet basic needs; or

5. Find stable housing.

(g) Refer participants requiring assistance with employment or vocational training to CareerSource Florida, Inc., and local workforce development boards or other entities to prepare, train, and place the participants in meaningful employment.

(3)(a) To participate in Hope Florida, an individual must be:

1. A legal resident of this state.

2. A citizen of the United States or a permanent resident alien of the United States, as determined by the United States Bureau of Citizenship and Immigration Services.

3.a. At least 18 years of age;

b. If emancipated, at least 16 years of age; or

c. If under 18 years of age and not emancipated, authorized to participate by written consent of his or her parent or guardian.

(b) Participation in Hope Florida is voluntary.

(c) Individuals may receive assistance by calling the Hope Line.

(4) The office shall designate a state agency to, at a minimum:

(a) Operate the Hope Line, which must be available, at a minimum, during business hours Monday through Friday.

(b) Develop and maintain a website for individuals to connect with Hope Florida.

(c) Develop and maintain a Hope Florida case management system that, at a minimum, conducts intake for Hope Florida inquiries and makes referrals for individuals and families in need of services.

Section 6. Section 23.45, Florida Statutes, is created to read:

23.45 Hope Navigators; care plans; Hope Florida partner network; participating state agencies.—

(1)(a) Hope Navigators are resources who must be embedded within communities and serve as catalysts and a single point of contact for participants. Hope Navigators shall use participant information to jointly develop and implement care plans and navigate and actively leverage community-based supports and opportunities to create a sustainable network of supports to help participants achieve their goals, overcome barriers, and realize their full potential.

(b) A care plan must, at a minimum, include actionable steps and corresponding timelines to address immediate, intermediate, and long-term goals and barriers to achieving such goals to help participants achieve their personal goals. Personal goals may include goals related to barriers to self-sufficiency.

(2) The Hope Florida partner network shall work to build a network of partnerships to sustain the effectiveness of Hope Florida.

(3)(a) State agencies shall participate in Hope Florida at the direction of the Executive Office of the Governor, including, but not limited to, the following agencies:

1. The Department of Children and Families.

2. The Agency for Persons with Disabilities.

3. The Department of Juvenile Justice.

4. The Statewide Guardian ad Litem Office.

5. The Department of Education.

6. The Agency for Health Care Administration.

7. The Division of Emergency Management.

8. The Department of Veterans' Affairs.

9. The Department of Commerce.

10. The Department of Elderly Affairs.

(b) In order to use government resources more effectively and efficiently, participating state agencies shall use existing resources and personnel, to the extent possible, to operate Hope Florida.

(c) Other public-private partners may also participate in Hope Florida at the direction of the office, including CareerSource Florida, Inc., and the Florida Commission on Community Service.

Section 7. This act shall take effect upon becoming 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 Appropriations Committee on Health and Human Services

BILL:	CS/SB 1146
INTRODUCER:	Governmental Oversight and Accountability Committee and Senator Burgess
SUBJECT:	Public Records/Hope Florida Program
DATE:	April 14, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harmsen	McVaney	GO	**Fav/CS**
2.	Sneed	McKnight	AHS	**Pre-meeting**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1146 is a public records companion bill to CS/SB 1144 (2025), to exempt from public records certain personal identifying information of participants in the Hope Florida program. The exemption applies to records held by the Hope Florida Office within the Executive Office of the Governor, and state agencies while administering the Hope Florida program, and is effective on, before, and after the bill takes effect.

This exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2030, unless saved by the Legislature from repeal.

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

This bill will have an insignificant negative fiscal impact on state expenditures that can be absorbed within existing resources. **See Section V., Fiscal Impact Statement.**

This bill takes effect on the same day as CS/SB 1144 (2025), or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

II. Present Situation:

Access to Public Records - Generally

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

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

Executive Agency Records – The Public Records Act

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

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

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

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[1] FLA. CONST. art. I, s. 24(a).
[2] *Id*. *See also*, *Sarasota Citizens for Responsible Gov't v. City of Sarasota*, 48 So. 3d 755, 762-763 (Fla. 2010).
[3] *See* Rule 1.48, *Rules and Manual of the Florida Senate*, (2022-2024) and Rule 14.1, *Rules of the Florida House of Representatives*, Edition 2, (2022-2024).
[4] *State v. Wooten*, 260 So. 3d 1060 (Fla. 4th DCA 2018).
[5] Section 119.01(1), F.S. Section 119.011(2), F.S., defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[6] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc*., 379 So. 2d 633, 640 (Fla. 1980).

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

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

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

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

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

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

such exemption on October 2 of the fifth year after its creation or substantial amendment, unless the Legislature reenacts the exemption.[19]

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

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

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

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

Hope Florida Program

CS/SB 1144, which is linked to this bill, statutorily creates the Hope Florida program and codifies the creation of a Hope Florida Office within the Executive Office of the Governor (EOG). The bill requires all state agencies to participate in Hope Florida if directed to do so by

[19] Section 119.15(3), F.S.
[20] Section 119.15(6)(b), F.S.
[21] Section 119.15(6)(b)1., F.S.
[22] Section 119.15(6)(b)2., F.S.
[23] Section 119.15(6)(b)3., F.S.
[24] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[25] *See generally* s. 119.15, F.S.
[26] Section 119.15(7), F.S.

the EOG. However, the Department of Children and Families, Agency for Persons with Disabilities, Department of Juvenile Justice, Statewide Guardian ad Litem Office, Department of Education, Agency for Health Care Administration, Division of Emergency Management, Department of Veterans' Affairs, Department of Commerce, and the Department of Elderly Affairs are required to participate.

The bill allows public-private partners, including CareerSource Florida and the Florida Commission on Community Service, to participate in Hope Florida at the direction of the Office.

The Hope Florida program is intended to "streamline access to support, services, and assistance so that residents in need can reach their full potential within their local communities and to holistically coordinate care through Hope Navigators." The program further strives to establish a seamless network of support systems managed through a centralized system that is composed of private businesses, nonprofit entities, state agencies, and faith-based organizations.

III. Effect of Proposed Changes:

Section 1 amends s. 23.44, F.S., to create a public records exemption making confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution, Hope Florida participants' personal identifying information. The exemption applies to records held by the Hope Florida Office, or participating state agencies for the purposes of operating the Hope Florida program. The exemption applies to all materials received on, before, or after the effective date of the bill.

The exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.15, F.S., and will stand repealed on October 2, 2030, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2 provides the constitutionally required public necessity statement, which states the Hope Florida program collects personal identifying information of its participants in order to fulfill its mission. These individuals are often in vulnerable situations and subject to abuse and exploitation. Allowing public access to participant data could impair the effective and efficient administration of the program and otherwise discourage individuals and families from seeking support through Hope Florida's resources.

The bill takes effect upon CS/SB 1144, or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof. CS/SB 1144, if passed, takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Not applicable. The bill does not require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, or reduce the percentage of state tax shared with counties or municipalities.

B. Public Records/Open Meetings Issues:

Vote Requirement

Article I, section 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 the personal identifying information for participants in the Hope Florida program and, thus, the bill requires a two-thirds vote to be enacted.

Public Necessity Statement

Article I, section 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 allowing access to the personal identification information of the program's participants could impair the effective and efficient administration of the Hope Florida program and otherwise discourage individuals and families from seeking support through Hope Florida's resources.

Breadth of Exemption

Article I, section 24(c) of the State Constitution requires an exemption to the public records requirements to be no broader than necessary to accomplish the stated purpose of the law. The purpose of the proposed law is to protect participants in the Hope Florida program and further the mission of the program.

This bill exempts the personal identifying information for participants in the Hope Florida program from the public records disclosure requirements. What personal identifying information means, however, is unclear.[27] Thus, the exemption may be broader than necessary to accomplish the purpose of the law.

The Legislature therefore may wish to clarify what personal identifying information is to ensure that the constitutional breadth of exemption requirement is met.

Additionally, this bill may grant greater protections to individuals who sign up for government services through, or with the assistance of, the Hope Florida program than for those who independently reach out to an agency. This application of exempt status to the same information that, when held in another fashion is not exempt, may make the breadth of this exemption suspect.

C. Trust Funds Restrictions:

None identified.

[27] *See infra* "VI. Technical Deficiencies."

D. State Tax or Fee Increases:

None identified.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None identified.

B. Private Sector Impact:

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

C. Government Sector Impact:

This bill may cause a minimal increase in workload on agencies holding records that contain personal identifying information of participants in the Hope Florida program because staff responsible for complying with public record requests may require training related to the new public record exemption. Additionally, agencies may incur costs associated with redacting the exempt information prior to releasing a record. However, the workload can be absorbed within existing resources.

VI. Technical Deficiencies:

The bill does not define the term "personal identifying information." As the term is not universally used throughout the Florida Statutes, it is unclear what specific information is exempted from public records disclosure and inspection requirements. The lack of clarity as to what personal identifying information means could also raise a constitutional question regarding the breadth of the exemption.[28] The Legislature may wish to clarify what specific information is encompassed by the term personal identifying information for this purpose.

Additionally, the bill does not define the term "public-private partners." The bill allows the Office to release confidential and exempt information to a "public-private partner," but what entities qualify as one is unclear.

VII. Related Issues:

None identified.

[28] *See supra* "IV. Constitutional Issue."

VIII. Statutes Affected:

This bill amends s. 23.44, which is created by linked SB 1144.

IX. Additional Information:

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

CS by Governmental Oversight and Accountability on April 1, 2025:

- Makes a Hope Florida program participant's personal identifying information exempt, rather than confidential and exempt, from public records disclosures requirements. This allows an agency records custodian who holds such exempt information to release it at his or her discretion.
- Applies the public records exemption to records held by the Hope Florida Office or a participating agency before, on, or after the effective date of the bill.

B. Amendments:

None.

By the Committee on Governmental Oversight and Accountability; and Senator Burgess

585-03146-25 20251146c1

A bill to be entitled

An act relating to public records; amending s. 23.44, F.S.; providing an exemption from public records requirements for the personal identifying information of a participant in the Hope Florida program contained in records held by the Hope Florida Office or any other agency designated to participate in the administering the program; providing retroactive application; providing for future legislative review and repeal; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Subsection (5) is added to section 23.44, Florida Statutes, as created by SB 1144 or similar legislation, 2025 Regular Session, to read:

23.44 Hope Florida Office; eligibility to participate; duties.—

(5)(a) A participant's personal identifying information contained in records held by the office or any other agency designated to participate in the administration of the program before, on, or after the effective date of this exemption is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(b) This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2030, unless reviewed and saved from repeal by the Legislature.

585-03146-25 20251146c1

Section 2. The Legislature finds that it is a public necessity to make the personal identifying information of Hope Florida participants contained in records held by the Hope Florida Office or any other agency that participates in the Hope Florida program exempt from public records requirements. The Hope Florida program collects personal identifying information regarding program participants in order to fulfill its mission to assist and serve Florida residents who are in vulnerable situations and subject to abuse or exploitation. The Hope Florida program collects information regarding its participants' employment status, housing status, domestic situation, and access to medical care and other basic needs. As such, information provided would be personal, sensitive information related to a person's physical or mental health or income status. Matters of personal health and financial status are traditionally private concerns, and for this reason, a person's expectation of a right to privacy regarding these matters necessitates the exemption. Furthermore, the exemption ensures the protection of the participant's identity, who may be subject to abuse or exploitation as a result of his or her vulnerable situation. If the participant's personal identifying information were not protected, the program's mission would be significantly impaired because applicants would be less inclined to participate if their personal information would be made available to the public. The Legislature finds that the harm that may result from the release of such information outweighs the public benefit that may be derived from the disclosure of the information.

Section 3. This act shall take effect on the same date that

SB 1144 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 Appropriations Committee on Health and Human Services

BILL:	SB 1182
INTRODUCER:	Senator Harrell
SUBJECT:	Medicaid Coverage of Continuous Glucose Monitors
DATE:	April 14, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Favorable**
2.	Barr	McKnight	AHS	**Pre-meeting**
3.			FP	

I. Summary:

SB 1182 directs the Agency for Health Care Administration (AHCA) to seek federal approval as needed to provide coverage of continuous glucose monitors (CGMs) and related supplies as a durable medical equipment benefit for Medicaid recipients.

The bill provides requirements related to reimbursement and claims submission. The bill also does not prevent the AHCA from providing additional coverage of CGMs as a Medicaid pharmacy benefit.

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

The bill takes effect upon becoming a law.

II. Present Situation:

What Is Diabetes?

Diabetes is a chronic health condition that affects how the human body turns food into energy.[1]

The human digestive system breaks down carbohydrates consumed as food into glucose[2] and releases it into the bloodstream, which increases the blood's glucose level. Such an increase in

[1] U.S. Centers for Disease Control and Prevention, *Diabetes Basics, available at* https://www.cdc.gov/diabetes/about/?CDC_AAref_Val=https://www.cdc.gov/diabetes/basics/diabetes.html (last visited Mar. 28, 2025).

[2] Glucose is the simplest type of carbohydrate (chemical formula $C_6H_{12}O_6$), and all carbohydrates consumed as food must be broken down into glucose before the body can metabolize them.

blood glucose should signal the pancreas[3] to release the hormone insulin, which acts as a catalyst to allow the body's cells to metabolize the glucose and convert it to energy, or to convert the glucose into forms suitable for short-term or long-term storage.[4]

With diabetes, depending on the type of diabetes, the pancreas either does not make any insulin or does not make enough insulin, or the body cannot use insulin as well as it should. When there is not enough insulin or cells stop responding to insulin, blood glucose levels elevate and stay elevated for extended periods. Over time, that can cause serious health problems, such as heart disease, vision loss, kidney disease, vascular disease, and other maladies. Such outcomes are often known as long-term complications of diabetes.[5]

According to the American Diabetes Association, approximately 2.1 million adults in Florida, or 11.4 percent of the adult population, have diabetes.[6]

Types of Diabetes

There are three main types of diabetes: Type 1, Type 2, and gestational diabetes.[7]

Type 1 Diabetes

Type 1 diabetes is thought to be caused by an autoimmune reaction in which the body's immune system attacks and destroys the cells in the pancreas that normally produce insulin. Approximately five percent[8] of people with diabetes have Type 1. Symptoms of Type 1 often develop quickly. It is usually diagnosed in children, teens, and young adults (which has led the condition to sometimes be referred to as "juvenile diabetes"). An individual with Type 1 diabetes must take insulin, usually through subcutaneous injections, on a regular basis to survive, usually one or more times per day. Currently, Type 1 diabetes can neither be prevented nor cured.[9]

Type 2 Diabetes

With Type 2 diabetes, the body does not use insulin well and cannot keep blood glucose at normal levels.[10] About 90 to 95 percent of people with diabetes have Type 2. It develops over many years and is usually diagnosed in overweight, middle-aged adults; however, manifestations

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[3] The pancreas is an organ located in the abdomen. It plays an essential role in converting food into fuel. The pancreas has two main functions: an exocrine function that helps in digestion and an endocrine function that regulates blood glucose. *See:* https://columbiasurgery.org/pancreas/pancreas-and-its-functions (last visited Mar. 15, 2025).

[4] U.S. Department of Health & Human Services, National Institutes of Health, National Library of Medicine, National Center for Biotechnology Information, *Physiology, Carbohydrates* (May 12, 2023), *available at* https://www.ncbi.nlm.nih.gov/books/NBK459280/#:~:text=As%20carbohydrates%20are%20consumed%2C%20the,liver%20to%20release%20stored%20glucose. (last visited Mar. 28, 2025).

[5] [5] U.S. Centers for Disease Control and Prevention, *Diabetes Basics, available at* https://www.cdc.gov/diabetes/about/?CDC_AAref_Val=https://www.cdc.gov/diabetes/basics/diabetes.html (last visited Mar. 28, 2025).

[6] American Diabetes Association, *The Burden of Diabetes in Florida, available at* https://diabetes.org/sites/default/files/2024-03/adv_2024_state_fact_florida.pdf (last visited Mar. 28, 2025).

[7] *Supra* note 5.

[8] American Diabetes Association, *Statistics About Diabetes, available at* https://diabetes.org/about-diabetes/statistics/about-diabetes (last visited Mar. 28, 2025).

[9] *Supra* note 5.

[10] *Id.*

in children, teens, and young adults have increased annually in recent years. Type 2 diabetes can often be prevented or delayed, or even eliminated altogether, with healthy lifestyle changes, such as losing weight, eating healthy food, and exercising regularly. Type 2 diabetes is usually treated with oral medications but can require insulin injections in some cases.[11]

Gestational Diabetes

Gestational diabetes develops in pregnant women who have never had diabetes. In pregnant women with gestational diabetes, the baby could be at higher risk for health problems. Gestational diabetes usually goes away after the baby is born; however, it correlates to a higher risk for Type 2 diabetes later in life. A baby delivered by a woman with gestational diabetes is more likely to become obese as a child or teen and to develop Type 2 diabetes later in life.[12]

Managing Diabetes

In order for Type 1 or Type 2 diabetics to avoid long-term complications, or for a pregnant woman with gestational diabetes to mitigate the effects of that condition, blood glucose levels must be managed to stay as close to normal ranges as possible.

The expected values for normal fasting blood glucose concentration are between 70 and 100 milligrams of glucose per deciliter (mg/dL) of whole blood, although normal levels may vary.[13]

Testing blood glucose levels is key to managing diabetes. Years of elevated blood glucose levels (hyperglycemia) can lead to diabetes' costly and disabling long-term complications, while levels that are too low (hypoglycemia) can be dangerous in an immediate sense and, in severe episodes, can lead to disorientation, unconsciousness, seizure, brain damage, or death.[14]

Blood Glucose Meters

Blood glucose meters are small devices used to measure an individual's blood glucose level at a specific point in time. To use a meter, a person inserts a test strip into the metering device, pricks one of his or her fingers with a lancing device (lancet) to draw a drop of blood, and then puts the blood drop onto the test strip, which causes a chemical reaction based on the presence of glucose in the blood. That chemical reaction can be detected and measured by the meter, which then displays a blood glucose reading, usually within a few seconds. After the reading, the used test strip must be discarded and a new one inserted to conduct a subsequent test.[15]

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[11] U.S. Centers for Disease Control and Prevention, *Type 2 Diabetes, available at* https://www.cdc.gov/diabetes/about/about-type-2-diabetes.html (last visited Mar. 28, 2025).
[12] U.S. Centers for Disease Control and Prevention, *Diabetes Basics, available at* https://www.cdc.gov/diabetes/about/?CDC_AAref_Val=https://www.cdc.gov/diabetes/basics/diabetes.html (last visited Mar. 28, 2025).
[13] World Health Organization, *Mean fasting blood glucose, available at* https://www.who.int/data/gho/indicator-metadata-registry/imrdetails/2380#:~:text=The%20expected%20values%20for%20normal,and%20monitoring%20glycemia%20are%20recommended. (last visited Mar. 28, 2025).
[14] Mayo Clinic, *Diabetic Coma, available at* https://www.mayoclinic.org/diseases-conditions/diabetic-coma/symptoms-causes/syc-20371475 (last visited Mar. 28, 2025).
[15] DiaTribe Learn: Making Sense of Diabetes, *Blood Glucose Meters: Uses, Types, and More* (Jul. 22, 2024), *available at* https://diatribe.org/diabetes-technology/blood-glucose-meters (last visited Mar. 28, 2025).

Continuous Glucose Monitors

Continuous glucose monitoring makes use of a specialized device to automatically track blood glucose levels throughout the day and night. Using a continuous glucose monitor (CGM) allows a diabetic to monitor glucose levels any time at a glance and to review how glucose levels have changed over a few minutes, hours, or days, to see trends, without drawing blood by pricking a finger. Seeing glucose levels in real-time and over periods of time can help diabetics make more informed decisions throughout the day about how to balance food intake, physical activity, and medicines.[16]

CGMs are approved in the U.S. for adults and children with a health care practitioner's prescription, although at least one such device is now available over-the-counter.[17] A CGM works through a tiny sensor inserted under the skin, usually via a small plastic disk or pod adhered to the abdomen or the backside of the upper arm. The sensor measures interstitial glucose level, which is the glucose found in the fluid between the cells. The sensor tests glucose every minute or every few minutes. A transmitter within the sensor wirelessly sends the information to a monitor, which can be a dedicated device or, in some cases, an app on a smartphone.[18]

CGMs are always on and recording glucose levels. Many CGMs have special features that work with information from glucose readings, such as:[19]

- An alarm can sound when the glucose level goes too low or too high.
- Data can be entered manually, regarding meals, physical activity, and medicines, so that such pertinent information can be recorded alongside glucose levels.
- Some models can send information in real-time to a second person's smartphone, such as a parent or caregiver. For example, if a child's glucose drops dangerously low overnight, the CGM could be set to wake a parent in the next room.
- CGM data can be stored on the Internet and made accessible to a diabetic's treating health care practitioner, who can use the data to help monitor and manage the diabetic's treatment.

Benefits of a CGM

Compared with a standard blood glucose meter, using a CGM system can help a diabetic to:[20]

- Better manage blood glucose levels every day.
- Have fewer emergencies relating to hypoglycemia.
- Need fewer finger sticks, which helps because the pain and bruising from repeated finger sticks can discourage the use of a blood glucose meter.

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[16] U.S. Department of Health & Human Services, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, *Continuous Glucose Monitoring, available at:* https://www.niddk.nih.gov/health-information/diabetes/overview/managing-diabetes/continuous-glucose-monitoring (last visited Mar. 28, 2025).
[17] U.S. Food and Drug Administration, *FDA Clears First Over-the-Counter Continuous Glucose Monitor, available at:* https://www.fda.gov/news-events/press-announcements/fda-clears-first-over-counter-continuous-glucose-monitor (last visited Mar. 29, 2025).
[18] *Supra* note 16.
[19] *Id.*
[20] *Id.*

A graphic on the CGM screen shows whether the blood glucose level is rising or dropping, and how quickly it may be rising or dropping, allowing the diabetic to make better decisions about his or her behavior in the short-term regarding the need for insulin, food, or whether exercise is a good or bad idea for that point in time.[21]

Over time, good management of glucose levels greatly helps individuals with diabetes stay healthy and prevent costly and potentially disabling complications of the disease.[22]

Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) is created under s. 20.42, F.S., to be the chief health policy and planning entity for the state, responsible for health facility licensure, inspection, and regulatory enforcement,[23] as well as the administration of Florida's Medicaid program.[24]

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[25] The federal Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for administering the Medicaid program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians and is financed through state and federal funds.[26]

The AHCA is responsible for establishing and maintaining a Medicaid state plan approved by the federal CMS, as well as maintaining any Medicaid waivers needed to operate the Florida Medicaid program as directed under the Florida Statutes,[27] the General Appropriations Act (GAA), and other legislation accompanying the GAA.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request from the federal CMS a formal waiver of the requirements codified in the

[21] U.S. Department of Health & Human Services, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, *Continuous Glucose Monitoring, available at:* https://www.niddk.nih.gov/health-information/diabetes/overview/managing-diabetes/continuous-glucose-monitoring (last visited Mar. 28, 2025).
[22] *Id*.
[23] Agency for Health Care Administration, *Health Quality Assurance, available at* https://ahca.myflorida.com/health-quality-assurance (last visited Mar. 28, 2025).
[24] Section 409.902, F.S.
[25] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid (last visited Mar. 28, 2025).
[26] Section 20.42, F.S.
[27] *See* parts III and IV of ch. 409, F.S., *available at* http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0409/0409.html (last visited Mar. 28, 2025).

federal Social Security Act. Federal waivers give states flexibility not afforded through their Medicaid state plan.[28]

Approximately 72.5 percent of Florida Medicaid recipients receive services through a Medicaid managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program while the remainder receive services that are paid for on a fee-for-service (FFS) basis.[29, 30] The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and the Prepaid Dental Health Program (Prepaid Dental).[31] Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.[32]

Medicaid Coverage of Prescribed Drugs

Medicaid managed care plans are required to provide all prescription drugs listed on the AHCA's Florida Medicaid Prescribed Drug List (PDL). As such, the AHCA's contracts with the managed care plans prevent them from implementing their own plan-specific formularies or PDLs and require the plans to provide a link to the AHCA's Medicaid PDL on their websites.[33]

Medicaid covers all U.S. Food and Drug Administration (FDA) approved prescription medications. Section 409.91195, F.S., outlines the development and management of the PDL. The AHCA uses clinical factors and its negotiations with drug manufacturers for monetary rebates when determining drugs to include on the PDL. State-negotiated supplemental rebates, along with federally required rebates, frequently result in discounted prescription cost for brand name drugs, potentially resulting in a cost to the state lower than that of its generic equivalent.[34]

Drugs not included on the PDL must be authorized by the AHCA's pharmacy benefit manager (PBM) prior to being dispensed. Additionally, the federal CMS allows states to cover non-pharmaceutical products under the pharmacy benefit if that product is FDA-approved and has been assigned a National Drug Code.[35,36]

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[28] Agency for Health Care Administration, *Senate Bill 1182 Bill Analysis* (Feb. 28, 2025) (on file with the Senate Committee on Health Policy).

[29] The other 27.5 percent of recipients receive Medicaid services through the fee-for-service (FFS) delivery model, where providers contract directly with the AHCA to render services, billing and receiving reimbursement directly from the AHCA; Florida Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).

[30] Agency for Health Care Administration, *Florida Statewide Medicaid Enrollment Report As of February 28, 2025 (including Medikids Population), available at* https://ahca.myflorida.com/content/download/26230/file/ENR_202502.xls (last visited Mar. 28, 2025).

[31] Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited Mar. 28, 2025).

[32] *Supra* note 28.

[33] Agency for Health Care Administration, *Senate Bill 988 Bill Analysis (2023)* (on file with the Senate Committee on Health Policy).

[34] *Id*.

[35] *Id*.

[36] Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which is a universal product identifier for human drugs; U.S. Food & Drug Administration, *National Drug Code Database Background Information, available at* https://www.fda.gov/drugs/development-approval-process-drugs/national-drug-code-database-background-information (last visited Mar. 28, 2025).

Medicaid Coverage of Durable Medical Equipment

Florida Medicaid reimburses for durable medical equipment (DME) and medical supplies appropriate for use in the recipient's home. DME may be rented, purchased, or rented-to-purchase. Examples of reimbursable equipment and supplies include:[37]

- Augmentative and assistive communication devices;
- Commodes;
- Enteral nutrition supplements;
- Hospital type beds and accessories;
- Mobility aids, including canes, crutches, walkers, and wheelchairs;
- Orthopedic footwear;
- Orthotic and prosthetic devices;
- Ostomy and urological supplies;
- Respiratory equipment and supplies, including nebulizers and oxygen; and
- Suction pumps.

The DME service benefit is one of the minimum covered services for all MMA and LTC plans serving Medicaid enrollees; however, all Medicaid recipients[38] may receive medically necessary DME and medical supplies services in accordance with coverage and limitations requirements[39] established by the AHCA.[40]

Medicaid Coverage of Diabetic Equipment and Supplies

Beginning October 1, 2024, the AHCA transitioned coverage of diabetic equipment and supplies from the DME benefit to be reimbursed through the pharmacy point-of-sale. This transition was authorized under HB 967 (2023), prioritizing both Medicaid recipients and taxpayer dollars as it allowed recipients to acquire diabetic supplies conveniently at a pharmacy and the AHCA to collect rebates for CGMs provided by the pharmacy, which the AHCA was unable to do prior to October 1, 2024.[41]

In order to collect rebates on CGMs and other diabetic supply products, the AHCA entered into a collaborative, multi-state agreement (pool) with the state's contracted PBM and 10 other states, allowing for more rebate negotiation using the state's collective power to reduce costs for CGM products. The AHCA also established a Medicaid Preferred Product List (PPL) that listed the items negotiated through the pool. Products not included on the PPL must be authorized by the AHCA's PBM prior to dispensing.[42]

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[37] Agency for Health Care Administration, *Durable Medical Equipment (DME) and Medical Supplies, available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/medical-and-behavioral-health-coverage-policy/specialized-health-services/durable-medical-equipment-dme-and-medical-supplies (last visited Mar. 28, 2025).
[38] Section 409.906(10), F.S.
[39] Agency for Health Care Administration, *Adopted Rules – Service Specific Policies, available at* https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies (last visited Mar. 28, 2025); *see* rules 59G-4.072, 59G-4.073, 59G-4.074, 59G-4.075, 59G-4.076, and 59G-4.077, F.A.C.
[40] *Supra* note 37.
[41] Agency for Health Care Administration, *Senate Bill 1182 Bill Analysis* (Feb. 28, 2025) (on file with the Senate Committee on Health Policy).
[42] *Id*.

Medicaid managed care plans are required to provide all CGMs and related products listed on the AHCA's PPL. As such, the plans cannot implement their own plan-specific formularies or PPLs and are required to provide a link to the AHCA's Medicaid PPL on their website. This allows the AHCA to collect rebates on both fee-for-service (FFS) and managed care claims. Both clinical factors and drug manufacturers' rebate offers are considered when determining products to include on the PPL.[43]

In 2021, Florida Medicaid spent nearly $40 million on diabetic supplies. Nearly half the expense was for glucose test strips, totaling $19 million for SMMC diabetic enrollees and $500,000 for FFS recipients. Additional diabetic supplies (e.g., glucose sensors, transmitters, insulin pumps,[44] needles, lancets, CGMs, syringes, glucose meters, alcohol swabs) accounted for the remaining approximately $19 million in SMMC diabetic enrollee expenses.[45]

Though most CGMs are covered only by pharmacies, the AHCA still allows CGMs and other diabetic supplies to be provided through the DME benefit under certain circumstances. In an effort to achieve the most patient-centric approach and promote a simplified patient experience, the AHCA has ensured recipients filling a traditional insulin pump are still able to receive their CGM products through a DME provider. To receive an insulin pump from a DME provider, recipients must present a prescription for the insulin pump to the DME provider. Once the prescription is provided, the insulin pump associated with Healthcare Common Procedure Coding System code[46] E0784 and all related supplies, including the associated CGM, will be covered. If a recipient is not eligible to receive an insulin pump from a DME provider, they must get their CGM product(s) at the pharmacy.[47]

The Florida Medicaid Diabetic Supply Services Coverage Policy,[48] as well as the Diabetic Supply Criteria,[49] can be viewed on the AHCA's website.[50]

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[43] Agency for Health Care Administration, *Senate Bill 1182 Bill Analysis* (Feb. 28, 2025) (on file with the Senate Committee on Health Policy).
[44] An insulin pump is a device that delivers insulin continuously and on-demand, mimicking the pancreas. Pumps deliver insulin through a tiny catheter that goes in a fleshy area of the body; Cleveland Clinic, *Type 1 Diabetes, available at* https://my.clevelandclinic.org/health/diseases/21500-type-1-diabetes#management-and-treatment (last visited Mar. 29, 2025).
[45] Agency for Health Care Administration, *Senate Bill 988 Bill Analysis (2023)* (on file with the Senate Committee on Health Policy).
[46] HCPCS codes are developed by the CMS and maintained by the American Medical Association. HCPCS codes are one of the primary medical languages used by health care providers to bill for procedures and services rendered; Centers for Medicare & Medicaid Services, *Healthcare Common Procedure Coding System (HCPCS), available at* https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system (last visited Mar. 28, 2025).
[47] *Supra* note 43.
[48] Agency for Health Care Administration, *Florida Medicaid Diabetic Supply Services Coverage Policy* (Sep. 2024), *available at* https://ahca.myflorida.com/content/download/25105/file/59G-4.252%20Diabetic%20Supply%20Services%20Coverage%20Policy_FINAL.pdf (last visited Mar. 28, 2025).
[49] Agency for Health Care Administration, *Diabetic Supply Criteria, available at* https://ahca.myflorida.com/content/download/25202/file/Diabetic_Supply_Criteria.pdf (last visited Mar. 29, 2025).
[50] Agency for Health Care Administration, *Diabetic Supply Services, available at* https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/pharmacy-policy/diabetic-supply-services (last visited Mar. 29, 2025).

III. Effect of Proposed Changes:

Section 1 requires the Agency for Health Care Administration (AHCA), within 30 days after this bill becomes a law, to seek federal approval through a Medicaid waiver or state plan amendment as needed to provide coverage of continuous glucose monitors (CGMs) and related supplies as a durable medical equipment (DME) benefit for Medicaid recipients. The bill requires that a licensed DME provider be reimbursed for CGMs and related supplies, provided the claim is submitted through an active Medicare Healthcare Common Procedure Coding System code. Under the bill, the AHCA may not require such provider to use a National Drug Code number as part of such claim submission.

The bill indicates that it does not preclude the AHCA from providing additional coverage of CGMs as a Medicaid pharmacy benefit.

The AHCA must begin implementation of the bill's provisions upon receiving any necessary federal approval.

Section 2 provides that the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Agency for Health Care Administration (AHCA) anticipates a fiscal impact to the Florida Medicaid Program of approximately $10 million annually. This estimate was calculated using the potential loss of rebates through the pharmacy benefit and the increased cost incurred from the utilization of non-preferred continuous glucose monitors (CGMs) and related supplies provided through the durable medical equipment (DME) benefit. The two primary inputs affecting loss of rebates are as follows:

- The AHCA's participation in pooled rebate negotiation is limited to collecting rebates for products listed on the Medicaid Preferred Product List (PPL). The bill would allow all CGM products, including those not included on the PPL, to be available through the DME benefit, which means that any product not provided by a pharmacy would not be eligible for a rebate.
- Rebate collection requires National Drug Code (NDC) reporting to capture the exact products that are dispensed, to accurately invoice manufacturers. This bill prohibits NDC reporting for products billed by a DME provider, which would prevent the state from collecting rebates on any products filled through the DME benefit.[51]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill creates undesignated sections of Florida law.

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.

[51]Agency for Health Care Administration, *Senate Bill 1182 Bill Analysis* (Feb. 28, 2025) (on file with the Senate Committee on Health Policy).

By Senator Harrell

31-01149A-25 20251182__

A bill to be entitled

An act relating to Medicaid coverage of continuous glucose monitors; requiring the Agency for Health Care Administration to, within a specified timeframe, seek federal approval as needed to provide coverage of continuous glucose monitors and related supplies as a durable medical equipment benefit under the Medicaid program; providing for the reimbursement of such equipment; providing construction; requiring the agency to implement these changes upon receiving any necessary federal approval; providing an effective date.

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

Section 1. (1) Within 30 days after this act becomes a law, the Agency for Health Care Administration shall seek federal approval through a Medicaid waiver or state plan amendment as needed to provide coverage of continuous glucose monitors and related supplies as a durable medical equipment benefit for Medicaid recipients. A licensed durable medical equipment provider must be reimbursed for continuous glucose monitors and related supplies, provided the claim is submitted through an active Medicare Healthcare Common Procedure Coding System. The agency may not require such provider to use a National Drug Code number as part of such claim submission.

(2) This section does not preclude the agency from providing additional coverage of continuous glucose monitors as a Medicaid pharmacy benefit.

31-01149A-25 20251182__

(3) The agency shall begin implementation of these changes upon receiving any necessary federal approval.

Section 2. This act shall take effect upon becoming a law.

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	CS/SB 1224
INTRODUCER:	Health Policy Committee and Senator Harrell
SUBJECT:	Administration of Controlled Substances
DATE:	April 14, 2025
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1224 amends s. 893.05, F.S., to allow a practitioner[1] to delegate to a certified paramedic the administration of a controlled substance if the paramedic is working under the direction and supervision of the practitioner and is in the course of providing emergency services.

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

The bill takes effect upon becoming a law.

II. Present Situation:

Paramedics

A paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical

[1] Section 893.02(23), F.S., defines "practitioner" to include a physician licensed under chapter 458, F.S., a dentist licensed under chapter 466, F.S., a veterinarian licensed under chapter 474, F.S., an osteopathic physician licensed under chapter 459, F.S., an advanced practice registered nurse licensed under chapter 464, F.S., a naturopath licensed under chapter 462, F.S., a certified optometrist licensed under chapter 463, F.S., a psychiatric nurse as defined in s. 394.455, F.S., a podiatric physician licensed under chapter 461, F.S., or a physician assistant licensed under chapter 458 or chapter 459, F.S., provided such practitioner holds a valid federal controlled substance registry number.

system. A paramedic possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive emergency medical system (EMS) response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance and are a link from the scene of an emergent encounter into the health care system.[2]

A paramedic in Florida is a person who is certified by the Department of Health (DOH) to perform both basic and advanced life support.[3,4,5] DOH Rule 64J-1.009, F.A.C., establishes requirements for qualifications to become a paramedic, including:

- Completing an initial Florida paramedic training course using the 2009 U.S. Department of Transportation (DOT) National EMS Education Standards;[6]
- Submitting an application;
- Attest that he or she is not addicted to alcohol or any controlled substance and that he or she is free from any physical or mental defect that might impair his or her ability to perform his or her duties;[7]
- Passing a paramedic certification exam within two years of completing the initial training program; and
- Specific to certification renewals, either retake the certification exam within the two-year licensure period or have completed 30 hours of continuing education and (for either option) maintain a current Advanced Cardiac Life Support card.

Medication Administration Training for Paramedics

The 2009 U.S. DOT National EMS Education Standards requires training on pharmacology. A paramedic is required to integrate comprehensive knowledge of pharmacology to formulate a treatment plan intended to mitigate emergencies and improve the overall health of the patient.[8] Paramedics are required to be trained in:

- Medication safety;
- Medication legislation;
- Naming;
- Classifications;
- Schedules;

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[2] 2009 U.S. DOT National EMS Education Standards, p. 10, *available at* https://www.ems.gov/assets/National-EMS-Education-Standards-FINAL-Jan-2009.pdf (last visited Mar. 21, 2025).
[3] Section 401.23(18), F.S.
[4] Section 401.23(9), F.S., defines "basic life support" as the assessment or treatment by a person qualified under this part through the use of techniques described in the EMT (Emergency Medical Technician) -Basic National Standard Curriculum or the National EMS (Emergency Medical Services) Education Standards of the United States Department of Transportation and approved by the DOH. The term includes the administration of oxygen and other techniques that have been approved and are performed under conditions specified by rules of the DOH.
[5] Section 401.23(2), F.S., defines "advanced life support" as assessment or treatment by a person qualified under this part through the use of techniques such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, cardiac defibrillation, and other techniques described in the EMT-Paramedic National Standard Curriculum or the National EMS Education Standards, pursuant to rules of the DOH.
[6] *Available at* https://www.ems.gov/assets/National-EMS-Education-Standards-FINAL-Jan-2009.pdf (last visited Mar. 21, 2025).
[7] Section 401.27(4)(b), and (c), F.S.
[8] *Supra* n. 2 at p. 15

- Pharmacokinetics;
- Storage and security;
- Autonomic pharmacology;
- Metabolism and excretion;
- Mechanism of action;
- Phases of medication activity;
- Medication response relationships;
- Medication interactions;[9]
- Toxicity.

Paramedics are required to be trained to a complex depth and comprehensive breadth in medication administration including routes of administration and how to administer medications within the scope of his or her authorization.[10]

Controlled Substances

Chapter 893, F.S., establishes the Florida Comprehensive Drug Abuse Prevention and Control Act (act). The act categorizes certain drugs and substances into schedules I-V which pertain to their potential for abuse.

- Schedule I substances have a high potential for abuse and has no currently accepted medical use in treatment in the United States and in their use under medical supervision does not meet accepted safety standards.
- Schedule II substances have a high potential for abuse and have a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence.
- Schedule III substances have a potential for abuse less than the substances contained in Schedules I and II and have a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage.
- Schedule IV substances have a low potential for abuse relative to the substances in Schedule III and have a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.
- Schedule V substances have a low potential for abuse relative to the substances in Schedule IV and have a currently accepted medical use in treatment in the United States, and abuse of such compound, mixture, or preparation may lead to limited physical or psychological dependence relative to the substances in Schedule IV.[11]

Unless specifically allowed under ch. 893 or ch. 499, F.S., a person may not sell, manufacture, deliver, or possess with the intent to sell, manufacture, deliver a controlled substance.[12] Health

[9] 2009 U.S. DOT National EMS Education Standards, p. 15, *available at* https://www.ems.gov/assets/National-EMS-Education-Standards-FINAL-Jan-2009.pdf (last visited Mar. 21, 2025).
[10] 2009 U.S. DOT National EMS Education Standards, p. 16, *available at* https://www.ems.gov/assets/National-EMS-Education-Standards-FINAL-Jan-2009.pdf (last visited Mar. 21, 2025).
[11] Section 893.03, F.S.
[12] Section 893.13, F.S.

care practitioners[13] are authorized under s. 893.05, F.S., to prescribe, administer, dispense, mix, or otherwise prepare a controlled substance or may cause the controlled substance to be administered by a licensed nurse or an intern practitioner under the practitioner's direction and supervision. Currently, ch. 893, F.S., does not authorize a practitioner to delegate the administration of a controlled substance to a paramedic.

III. Effect of Proposed Changes:

The bill amends s. 893.05, F.S., to allow a practitioner to delegate the administration of a controlled substance to a certified paramedic who is working under the direction and supervision of the practitioner in the course of providing emergency services.

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

[13] As defined in s. 893.02, F.S. *See* n. 1.

C. Government Sector Impact:

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

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 893.05 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on March 25, 2025:
The committee substitute specifies that a paramedic may only administer controlled substances when delegated the duty in the course of providing emergency services.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Harrell

588-02847-25 20251224c1

A bill to be entitled

An act relating to the administration of controlled substances; amending s. 893.05, F.S.; authorizing a practitioner to cause a controlled substance to be administered by a certified paramedic in the course of providing emergency services; providing an effective date.

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

Section 1. Paragraph (a) of subsection (1) of section 893.05, Florida Statutes, is amended to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1)(a) A practitioner, in good faith and in the course of his or her professional practice only, may prescribe, administer, dispense, mix, or otherwise prepare a controlled substance, or the practitioner may cause the controlled substance to be administered, under his or her direction and supervision only, by a certified paramedic in the course of providing emergency services, ~~by~~ a licensed nurse, or an intern practitioner ~~under his or her direction and supervision only~~.

Section 2. This act shall take effect upon becoming 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 Appropriations Committee on Health and Human Services

BILL:	CS/SB 1240
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Calatayud
SUBJECT:	Substance Abuse and Mental Health Care
DATE:	April 14, 2025 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1240 integrates the 988 Suicide and Crisis Lifeline Call Center into the state mental health crisis response network and requires the Department of Children and Families (DCF) to authorize, regulate, and oversee Florida's 988 Lifeline program.

The bill removes the "needs assessment" requirement for licensure of medication-assisted treatment (MAT) programs for opioid addiction.

The bill establishes enhanced training standards for mental health professionals conducting forensic evaluations, emphasizing competency restoration, evidence-based practices, and placement alternatives to ensure consistent and effective forensic evaluations. The bill requires court-appointed mental health experts performing forensic evaluations to complete DCF-approved forensic training and ongoing education.

The bill also requires mental health professionals to assess the availability of community-based treatment before recommending involuntary hospitalization.

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

The bill takes effect July 1, 2025.

II. Present Situation:

The present situation for each issue is described below in Section III, Effect of Proposed Changes.

III. Effect of Proposed Changes:

The bill makes changes to Florida's mental health and substance abuse coordinated system of care by integrating crisis services, expanding treatment accessibility, and strengthening provider oversight. The bill improves response times for mental health emergencies, streamlines treatment, and enhances training for behavioral health professionals.

Background

Mental Health and Mental Illness

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

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

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. Nearly one in five adults lives with a mental illness.[4] During childhood and adolescence, almost half of children will experience a mental disorder, though the proportion experiencing severe impairment during childhood and adolescence is lower, at about 22 percent.[5]

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[1] World Health Organization, *Mental Health: Concepts in Mental Health*, available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited 3/7/25).
[2] Centers for Disease Control and Prevention, *Mental Health Basics*, available at: http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited 3/7/25).
[3] *Id.*
[4] National Institute of Mental Health (NIHM), *Mental Illness*, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited 3/7/25).
[5] *Id.*

Florida Mental Health and Substance Abuse Services Acts

The Department of Children and Families (DCF) administers a statewide system of safety net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services.[6] The DCF is charged with providing a coordinated system of care, to serve as a "no-wrong-door model" that provides a comprehensive array of behavioral health services from front end crisis intervention through long-term recovery services, including a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services.[7]

988 Suicide and Crisis Lifeline

Present Situation

The 988 Suicide and Crisis Lifeline is the national three-digit telephone number available for mental health crises, providing a 24/7 connection to free and confidential emotional support.[8] Launched on July 16, 2022, 988 was established by federal law as an easy-to-remember alternative to the 10-digit National Suicide Prevention Lifeline.[9] By dialing 988 (or texting 988, or using web chat), callers in distress are routed to one of over 200 local crisis centers nationwide, where trained crisis counselors provide immediate counseling, support, and referrals to resources.[10] By May 2024, nearly two years post-launch, the 988 Lifeline had fielded 10.8 million interactions nationwide, comprising roughly 6.4 million calls, 1.6 million chats, and 1.6 million texts.[11]

The federal government established the 988 Suicide and Crisis Lifeline with the intention of turning over its oversight and funding responsibilities to the states in 2026.

Since July 2022, the in-state 988 Lifeline program known as the Florida 988 Lifeline (988 Lifeline) has connected 95,672 individuals to mental health or related services and offered telephone-based support to 398,939 people across the state.[12] The 988 Lifeline network ensures individuals have immediate access to trained professionals through a centralized helpline which ultimately reduces dependence on 911 calls and law enforcement for mental health emergencies.

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[6] *See generally*, Part I, Ch. 394, F.S., and Ch. 397, F.S.
[7] *See* s. 394.4573, F.S.
[8] 988 Suicide & Crisis Lifeline, *The Lifeline and 988*, available at: https://988lifeline.org/current-events/the-lifeline-and-988/#:~:text=On%20July%2016%2C%202022%2C%20the,Vibrant (last visited 3/7/25).
[9] KFF, *One Year After the Launch of 988, the National Suicide and Crisis Hotline Has Received Nearly 5 Million Combined Calls, Texts, and Chats*, Available at: https://www.kff.org/mental-health/press-release/one-year-after-the-launch-of-988-the-national-suicide-and-crisis-hotline-has-received-nearly-5-million-combined-calls-texts-and-chats/#:~:text=Overall%2C%20the%20988%20line%20steers,mental%20health%20crisis%20to%20recall (last visited 3/7/25).
[10] 988 Suicide & Crisis Lifeline, *The Lifeline and 988*, available at: https://988lifeline.org/current-events/the-lifeline-and-988/#:~:text=On%20July%2016%2C%202022%2C%20the,Vibrant (last visited 3/7/25).
[11] KFF, *988 Suicide & Crisis Lifeline: Two Years After Launch*, available at: https://www.kff.org/mental-health/issue-brief/988-suicide-crisis-lifeline-two-years-after-launch/#:~:text=Since%20launch%20in%20July%202022%2C,third%20of%20total%20contacts%2C%20accounting (last visited 3/7/25).
[12] Department of Children and Families, 2025 Agency Analysis, p. 2 (on file with the Children, Families, and Elder Affairs Committee).

Effect of Proposed Changes

Section 1 amends s. 394.4573, F.S., to add the 988 Suicide and Crisis Lifeline Call Center as a statutorily required part of the state's crisis response as part of the behavioral health coordinated system of care. This change places the duties of regulation and assessment of the 988 Suicide Crisis Lifeline with the DCF.

Section 6 amends s. 394.67, F.S., to define "988 Suicide and Crisis Lifeline Call Center" to mean a call center that meets national accreditation and is recognized by the DCF to receive 988 calls, texts, or other forms of communication. The bill adds the 988 Suicide and Crisis Lifeline Call Center to the definition of "mental health crisis services." These changes integrate the role of 988 centers into the state's behavioral health system, specifically as a crisis response service.

Section 7 creates s. 394.9088, F.S., to require the DCF to authorize and provide oversight to the 988 network crisis call centers. The bill prohibits 988 services from being provided by non-authorized call centers. The bill allows the DCF to ensure compliance with state and federal crisis response standards, improving service quality, and establishing a framework for coordination between 988 and 911 emergency services.

Medication-Assisted Treatment (MAT) Needs Assessment

Present Situation

Medication-Assisted Treatment (MAT) for opioid use disorders is a service that uses methadone or other medication as authorized by state and federal law, in combination with medical, rehabilitative, supportive, and counseling services in the treatment of individuals who are dependent on opioid drugs.[13] This integrated approach aims to provide a whole-patient treatment strategy.[14] Medications commonly used in MAT include methadone, buprenorphine, and naltrexone, which work by reducing cravings, alleviating withdrawal symptoms, and blocking the euphoric effects of substances.[15]

Current law requires the DCF to determine the need for new MAT providers in the state.[16] This requirement does not allow opioid treatment programs (OTPs) or methadone clinics to open freely at will; instead, new clinics can only be established if the DCF finds there is an unmet need in a region for additional services.[17] This needs-based licensure process serves as a state-level control on the number and location of MAT clinics.

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[13] Section 397.311,7

[14] Department of Health – Palm Beach County, *Medication Assisted Treatment (MAT)*, https://palmbeach.floridahealth.gov/programs-and-services/OD2A/_documents/Fact-Sheet-Medication-Assisted-Treatment.pdf (last visited March 17, 2025)

[15] Substance Abuse and Mental Health Services Administration, *Find Substance Use Disorder Treatment*, available at https://www.samhsa.gov/substance-use/treatment/find-treatment (last visited March 17, 2025); Addiction Group, *What is Medication-Assisted Treatment (MAT)*, available at https://www.addictiongroup.org/treatment/therapies/mat/ (last visited March 17, 2025)

[16] Section 397.427, F.S.

[17] *Id.*

Florida currently has 72 operational MAT clinics, collectively assisting nearly 22,000 clients statewide.[18] However, under the current federal methodology, three needs assessments have been conducted since Fiscal Year 2018-2019, and none have identified a statewide need for additional facilities. The DCF lacks the flexibility to grant licenses outside of the annual needs-based determination process, even in urgent situations such as the closure of the only clinic in a given area.[19]

The federal algorithm presents additional challenges in addressing the needs of jail-based and rural populations. Current law does not exempt agencies that serve specific limited groups such as jails, prisons, and federally qualified health centers.[20] Providing these facilities with the flexibility to offer services as needed would improve access to care for those specialized populations.

Effect of Proposed Changes

Section 8 deletes s. 397.427(2) and amends s. 397.427(4), F.S., to remove the requirement that the DCF conduct Methadone MAT Needs Assessments annually. The proposed change will deregulate the process, allowing any interested provider to apply for an MAT maintenance license without the need for a certificate of need. This change will expedite the process to open a facility or operate a mobile MAT unit as they will not have to await an award of a certificate of need. This change will increase access to treatment, particularly in smaller, less populous counties. Additionally, removing the certificate of need requirement will provide greater flexibility for mobile MAT clinics, enabling providers to expand beyond their brick-and-mortar locations to better serve communities. The overall intended effect of repealing this requirement is a significant decrease in overdose deaths due to opioid use

Forensic Evaluators

Present Situation

Chapter 916, F.S., establishes the Forensic Client Services Act detailing the framework for addressing mental health issues within the state's criminal justice system, specifically requiring the DCF to establish, locate, and maintain facilities and programs for the treatment or training of defendants who have been charged with a felony and who have been found to be incompetent to proceed in the legal system due to mental illness.[21] The law guides how courts appoint mental health experts, assess a defendant's competency to stand trial, and manage individuals found not guilty by reason of insanity.

Mental health evaluations ensure that defendants with mental health conditions receive proper assessment and treatment. Courts appoint licensed psychiatrists, psychologists, or physicians to determine a defendant's competency, sanity, or need for involuntary treatment.[22] These professionals have specific forensic training and a one-time class from the DCF. These

[18] Department of Children and Families, 2025 Agency Analysis, pg.2 (on file with the Children, Families, and Elder Affairs Committee).
[19] *Id.*
[20] *Id.*
[21] Chapter 916, F.S.
[22] Section s. 916.11, F.S.

evaluations conducted in jails, forensic centers, or medical facilities, help courts decide whether a defendant can stand trial or requires hospitalization. If deemed incompetent, individuals may be committed to a DCF facility for treatment until they can participate in legal proceedings or, if their behavior is non-threatening, may be released under supervision.[23]

Defendants found not guilty by reason of insanity may be involuntarily committed if they pose a danger to themselves or others.[24] Placement in a State Mental Health Treatment Facility (SMHTF) ensures access to necessary treatment while maintaining public safety. Regular evaluations determine whether continued hospitalization is required or if a supervised release plan is appropriate. Mental health professionals conduct these assessments, provide expert testimony, and oversee treatment, helping courts balance the needs of individuals with mental illness against legal and public safety concerns.[25]

Florida faces growing challenges with increasing referrals to the SMHTFs from courts and forensic hospital bed occupancy rates above 97%. These challenges delay care and leave individuals in jail awaiting inpatient services. With 462 people on the waitlist and 333 waiting more than 15 days, the backlog continues to strain the system.[26] However, many of these individuals could be restored to competency through less restrictive alternatives, reducing the need for full hospitalization in a SMHTF. Court decisions on commitment orders are heavily influenced by evaluators' findings and recommendations, which help determine the most appropriate treatment setting.[27]

In 2023, changes to Chapter 916, F.S., introduced a requirement for expert evaluators and courts to assess alternative treatment options before committing a defendant to a SMHTF. Evaluators are expected to provide a comprehensive report on available alternatives, including a thorough justification if those options are deemed inadequate.[28] Evaluators must consider a list of minimum alternative treatment options before ordering a defendant to be placed in a treatment facility. Experts must also report on the appropriateness of the following community-based options for treating and supporting the recovery of a patient:[29]

- Mental health services;
- Treatment services;
- Rehabilitative services;
- Support services; and
- Case management services as those terms are defined in s. 394.67(16), F.S., which may be provided by or within:
  - Multidisciplinary community treatment teams;
  - Community treatment teams, such as Florida Assertive Community Treatment (FACT) teams;
  - Conditional release programs;

[23] Section 916.12, F.S.
[24] Section 916.15, F.S.
[25] *Id*.
[26] Department of Children and Families, 2025 Agency Analysis, p. 3 (on file with the Children, Families, and Elder Affairs Committee).
[27] *Id*.
[28] *Id*.
[29] Section 916.12, F.S.

- Outpatient services or intensive outpatient treatment programs; and
- Supportive employment and supportive housing opportunities.[30]

However, the implementation of this requirement has not been consistent statewide. Without a legal requirement for forensic evaluators to participate in ongoing training, evaluators lack critical updates on new or revised statutes, alternative placements, and least restrictive options.[31]

Effect of Proposed Changes

Section 10 amends s. 916.111, F.S., to update training requirements for mental health professionals conducting forensic evaluations. The bill requires training on statutes and rules related to competency restoration, evidence-based practices, and least restrictive treatment alternatives and placements. This change will require trainings to be more accurate, aligned with current law, and produce more standardized evaluations in legal proceedings.

Section 11 amends s. 916.115, F.S., to require court-appointed mental health experts to complete both an initial and ongoing DCF-approved forensic training. The bill requires those experts performing juvenile evaluations to complete annual juvenile forensic competency evaluation training and requires all current expert evaluators to complete the newly created DCF-provided continuing education for experts by July 1, 2026 to remain an active evaluator.

These increased training requirements for expert forensic evaluators is intended to improve the consistency of evaluations and ultimately, the judicial decision-making in criminal cases involving defendants with mental illness.

Section 12 amends s. 916.12, F.S., to require mental health evaluators to assess whether less restrictive treatment alternatives are available in the community and acceptable. The bill requires this assessment to involve the use of current resources and information, and include the ongoing DCF-approved training. This change is intended to ensure individuals receive care in the least restrictive setting possible to eliminate the need for unnecessary institutionalization.

Conforming Language and Cross-Reference Changes to Align with 2024 Legislation

Present Situation

A number of bills were introduced and passed during the 2024 legislative session. CS/SB 7016 was the flagship of the 2024 "Live Healthy" initiative. The bill revised preexisting health care programs, created new programs, revised licensure and regulatory requirements for health care practitioners and facilities, created new provisions within programs relating to health care practitioner education, amended the state Medicaid program, and appropriated both general revenue and trust fund dollars for the purpose of growing Florida's health care workforce and increasing access to health care services.

CS/CS/HB 7021 made substantive changes to both Florida's Baker and Marchman Acts by combining processes for courts to order individuals to involuntary outpatient services and

[30] Section 394.67, F.S.
[31] *Id.*

involuntary inpatient placement in the Baker Act. This bill streamlined the process for obtaining involuntary services and provided more flexibility for courts to meet individuals' treatment needs. The bill also integrated existing provisions for court-ordered involuntary assessments and stabilization in the Marchman Act into a new consolidated involuntary treatment process.

Effect of the Bill

The bill makes multiple conforming language changes to clarify and refine provisions and further align current law with the changes in the 2024 legislation.

Sections 2, 3, 4, and 5 amends multiple sections of ch. 394, F.S., to make conforming language and cross-reference changes to align current law with the substantive changes of HB 7021 (2024) and SB 7016 (2024). Specifically, the bill amends current law to:

- Clarify that a guardian advocate is to be discharged when a patient is discharged from an order for involuntary outpatient services, involuntary inpatient placement, or when the patient is transferred from involuntary to voluntary status.
- Require a qualified mental health professional to review a voluntary patient discharge request within 12 hours.
- Clarify that a clinical psychologist must have three years of clinical training in the practice of clinical psychology.
- Require that petitioners prepare a services plan for patients prior to submitting an order for involuntary outpatient placement services.
- Define the responsibilities of administrative law judges and courts regarding involuntary inpatient placement and involuntary outpatient services.

Sections 13 and 14 make conforming cross-reference changes.

The bill takes effect July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill has no fiscal impact on state expenditures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends the following sections of the Florida Statutes: 394.4573, 394.67, 397.427, 916.111, 916.115, 916.12, 394.674, and 394.74.

This bill creates s. 394.9088 of the Florida Statutes.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs on March 19, 2025:
The CS makes the following changes:

- Clarifies that a guardian advocate is to be discharged of responsibility when a patient enters involuntary outpatient services.
- Requires a clinical psychologist to have three years of clinical training in the practice of clinical psychology.
- Allows the court to order involuntary outpatient placement based on expanded criteria.
- Mandates that petitioners prepare service plans for patients prior to submitting an order for involuntary outpatient placement services.

- Defines the responsibilities of administrative law judges and courts regarding involuntary inpatient placement and involuntary outpatient services.

B. Amendments:

None.

532552

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Between lines 118 and 119
insert:

Section 4. Paragraph (i) of subsection (2) of section 394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(i) One of the following must occur within 24 ~~12~~ hours after the patient's attending physician documents that the

532552

patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a facility and released; or

2. The patient must be accepted for transfer ~~transferred~~ to a designated facility in which appropriate medical treatment is available. However, the facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

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

And the title is amended as follows:

Delete line 12

and insert:

experience; amending s. 394.463, F.S.; revising the timeframe within which a receiving facility must take certain actions after the attending physician of a patient being involuntarily examined documents certain information about the patient's medical condition; revising a required action; amending s. 394.4655, F.S.; providing

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

586-02608-25 20251240c1

A bill to be entitled

An act relating to substance abuse and mental health care; amending s. 394.4573, F.S.; expanding mental health crisis services to include the 988 suicide and crisis lifeline call center; amending s. 394.4598, F.S.; authorizing the guardian advocate to be discharged when a patient is discharged from involuntary outpatient services; amending s. 394.4625, F.S.; requiring clinical psychologists who make determinations of involuntary placement at certain mental health facilities to have specified clinical experience; amending s. 394.4655, F.S.; providing cross-reference for specified criteria relating to orders to involuntary outpatient placement; amending s. 394.467, F.S.; providing that orders entered by administrative law judges for continued involuntary placement for patients at certain mental health facilities are final and subject to judicial review; requiring hearings to be scheduled immediately; requiring the clerk of the Division of Administrative Hearings to provide copies of petitions and individualized plans for continued services to the Department of Children and Families and other specified individuals; requiring the court or the administrative law judge to make certain determinations before waiving a patient's attendance at a hearing for continued involuntary placement; authorizing an administrative law judge to issue an order for involuntary services if the patient meets

586-02608-25 20251240c1

certain criteria; amending s. 394.67, F.S.; revising the definition of "crisis services" to include a 988 suicide and crisis lifeline call center and defining the term "988 suicide and crisis lifeline call center"; creating s. 394.9088, F.S.; requiring the Department of Children and Families to authorize and provide oversight of the 988 suicide and crisis lifeline call centers and adopt specified rules; amending s. 397.427, F.S.; removing requirements relating to providers of medication-assisted treatment services for opiate addiction; amending s. 916.111, F.S.; revising training requirements for mental health professionals; amending s. 916.115, F.S.; requiring court appointed experts to have completed specified training and continued education; amending s. 916.12, F.S.; providing requirements for an expert to determine acceptable treatments available in a community; amending ss. 394.674, 394.74, and 397.68141 F.S.; conforming cross-references; providing an effective date.

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

Section 1. Paragraph (d) of subsection (2) of section 394.4573, Florida Statutes, is amended to read:

394.4573 Coordinated system of care; annual assessment; essential elements; measures of performance; system improvement grants; reports.—On or before December 1 of each year, the department shall submit to the Governor, the President of the

Senate, and the Speaker of the House of Representatives an assessment of the behavioral health services in this state. The assessment shall consider, at a minimum, the extent to which designated receiving systems function as no-wrong-door models, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, and the use of evidence-informed practices. The assessment shall also consider the availability of and access to coordinated specialty care programs and identify any gaps in the availability of and access to such programs in the state. The department's assessment shall consider, at a minimum, the needs assessments conducted by the managing entities pursuant to s. 394.9082(5). The department shall compile and include in the report all plans submitted by managing entities pursuant to s. 394.9082(8) and the department's evaluation of each plan.

(2) The essential elements of a coordinated system of care include:

(d) Crisis services, including the 988 suicide and crisis lifeline call center, mobile response teams, crisis stabilization units, addiction receiving facilities, and detoxification facilities.

Section 2. Subsection (8) of section 394.4598, Florida Statutes, are amended to read:

394.4598 Guardian advocate.—

(8) The guardian advocate shall be discharged when the patient is discharged from an order for involuntary outpatient services ~~placement~~ or involuntary inpatient placement or when the patient is transferred from involuntary to voluntary status.

The court or a hearing officer shall consider the competence of the patient pursuant to subsection (1) and may consider an involuntarily placed patient's competence to consent to treatment at any hearing. Upon sufficient evidence, the court may restore, or the hearing officer may recommend that the court restore, the patient's competence. A copy of the order restoring competence or the certificate of discharge containing the restoration of competence shall be provided to the patient and the guardian advocate.

Section 3. Subsection (5) of section 394.4625, Florida Statutes, is amended to read:

394.4625 Voluntary admissions.—

(5) TRANSFER TO INVOLUNTARY STATUS.—When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, a clinical psychologist with at least 3 years of clinical ~~postdoctoral~~ experience ~~in the practice of clinical psychology~~, or a psychiatrist as quickly as possible, but not later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient must be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the order of a physician or a psychiatric nurse practicing within the framework of an established protocol with a

psychiatrist, if it is determined that such treatment is necessary for the safety of the patient or others.

Section 4. Subsection (2) of section 394.4655, Florida Statutes, is amended to read:

394.4655 Orders to involuntary outpatient placement.—

(2) A court or a county court may order an individual to involuntary outpatient placement under s. 394.467. The criteria for ordering a person to involuntary outpatient placement, as well as all of the requirements and processes for placement, including, but not limited to, recommendations for involuntary outpatient placement, petitions, appointment of counsel, and hearings on involuntary outpatient placement are provided in s. 394.467.

(3) When recommending an order to involuntary outpatient placement, the petitioner, as defined in s. 394.467(4), shall prepare a services plan for the patient in accordance with s. 394.467.

Section 5. Paragraph (a) of subsection (1) and subsection (11) of section 394.467, Florida Statutes, are amended to read:

394.467 Involuntary inpatient placement and involuntary outpatient services.—

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

(a) "Court" means a circuit court or, for commitments only to involuntary outpatient services ~~as defined in s. 394.4655~~, a county court.

(11) PROCEDURE FOR CONTINUED INVOLUNTARY SERVICES.—

(a) A petition for continued involuntary services must be filed if the patient continues to meet ~~meets~~ the criteria for involuntary services.

(b)1. If a patient receiving involuntary outpatient services continues to meet the criteria for involuntary outpatient services, the service provider must file in the court that issued the initial order for involuntary outpatient services a petition for continued involuntary outpatient services.

2. If a patient in involuntary inpatient placement continues to meet the criteria for involuntary services and is being treated at a receiving facility, the administrator must, before the expiration of the period the receiving facility is authorized to retain the patient, file in the court that issued the initial order for involuntary inpatient placement, a petition requesting authorization for continued involuntary services. The administrator may petition for inpatient or outpatient services.

3. If a patient in involuntary inpatient placement continues to meet the criteria for involuntary services and is being treated at a treatment facility, the administrator must, before expiration of the period the treatment facility is authorized to retain the patient, file a petition requesting authorization for continued involuntary services. The administrator may petition for inpatient or outpatient services. Hearings on petitions for continued involuntary services of an individual placed at any treatment facility are administrative hearings and must be conducted in accordance with s. 120.57(1), except that any order entered by the administrative law judge is final and subject to judicial review in accordance with s. 120.68. Orders concerning patients committed after successfully pleading not guilty by reason of insanity are governed by s.

916.15.

4. ~~The court shall immediately schedule~~ A hearing on the petition shall ~~to~~ be scheduled immediately and held within 15 days after the petition is filed.

5. The existing involuntary services order shall remain in effect until disposition on the petition for continued involuntary services.

(c) The petition must be accompanied by a statement from the patient's physician, psychiatrist, psychiatric nurse, or clinical psychologist justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services, and an individualized plan of continued treatment developed in consultation with the patient or the patient's guardian advocate, if applicable. If the petition is for involuntary outpatient services, it must comply with the requirements of subparagraph (4)(d)3. When the petition has been filed, the clerk of the court or the clerk of the Division of Administrative Hearings, as applicable, shall provide copies of the petition and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.

(d) The court shall appoint counsel to represent the person who is the subject of the petition for continued involuntary services in accordance with the provisions set forth in subsection (5), unless the person is otherwise represented by counsel or ineligible.

(e) Hearings on petitions for continued involuntary outpatient services must be before the court that issued the

order for involuntary outpatient services. However, the patient and the patient's attorney may agree to a period of continued outpatient services without a court hearing.

(f) Hearings on petitions for continued involuntary inpatient placement in receiving facilities, or involuntary outpatient services following involuntary inpatient services, must be held in the county or the facility, as appropriate, where the patient is located.

(g) The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph must meet the requirements of subsection (7).

(h) Notice of the hearing must be provided as set forth in s. 394.4599.

(i) If a patient's attendance at the hearing is voluntarily waived, the court or the administrative law judge must determine that the patient knowingly, intelligently, and voluntarily waived his or her right to be present, before waiving the presence of the patient from all or a portion of the hearing. Alternatively, if at the hearing the court or the administrative law judge finds that attendance at the hearing is not consistent with the best interests of the patient, the court or the administrative law judge may waive the presence of the patient from all or any portion of the hearing, unless the patient, through counsel, objects to the waiver of presence. The testimony in the hearing must be under oath, and the proceedings must be recorded.

(j) If at a hearing it is shown that the patient continues to meet the criteria for involuntary services, the court or the administrative law shall issue an order for continued

involuntary outpatient services, involuntary inpatient placement, or a combination of involuntary services for up to 6 months. The same procedure shall be repeated before the expiration of each additional period the patient is retained.

(k) If the patient has been ordered to undergo involuntary services and has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. If the patient's competency to consent to treatment is restored, the discharge of the guardian advocate is governed by s. 394.4598. If the patient has been ordered to undergo involuntary inpatient placement only and the patient's competency to consent to treatment is restored, the administrative law judge may issue a recommended order, to the court that found the patient incompetent to consent to treatment, that the patient's competence be restored and that any guardian advocate previously appointed be discharged.

(l) If continued involuntary inpatient placement is necessary for a patient in involuntary inpatient placement who was admitted while serving a criminal sentence, but his or her sentence is about to expire, or for a minor involuntarily placed, but who is about to reach the age of 18, the administrator shall petition the administrative law judge for an order authorizing continued involuntary inpatient placement.

The procedure required in this subsection must be followed before the expiration of each additional period the patient is involuntarily receiving services.

Section 6. Present subsections (1) through (25) of section 394.67, Florida Statutes, are redesignated as subsections (2)

through (26), respectively, subsection (4) is amended, and a new subsection (1) is added to that section, to read:

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

(1) "988 suicide and crisis lifeline call center" means a call center meeting national accreditation and recognized by the department to receive 988 calls, texts, or other forms of communication in this state.

(4) "Crisis services" means short-term evaluation, stabilization, and brief intervention services provided to a person who is experiencing an acute mental or emotional crisis, as defined in subsection (19) ~~(18)~~, or an acute substance abuse crisis, as defined in subsection (20) ~~(19)~~, to prevent further deterioration of the person's mental health. Crisis services are provided in settings such as a crisis stabilization unit, an inpatient unit, a short-term residential treatment program, a detoxification facility, or an addictions receiving facility; at the site of the crisis by a mobile crisis response team; or at a hospital on an outpatient basis; or telephonically by a 988 suicide and crisis lifeline call center.

Section 7. Section 394.9088, Florida Statutes, is created to read:

394.9088 988 suicide and crisis lifeline call center.—

(1) The department shall authorize and provide oversight to 988 suicide and crisis lifeline call centers. Unless authorized by the department, call centers are not permitted to conduct 988 suicide and crisis lifeline services. The department may implement a corrective action plan, suspension, or revocation of authorization for failure to comply with this section and rules adopted under this section.

(2) The department shall adopt rules relating to:

(a) The process for authorization of 988 suicide and crisis lifeline call centers.

(b) Minimum standards for 988 suicide and crisis lifeline call centers to be authorized, including but not limited to, service delivery, quality of care, and performance outcomes.

(c) The adequacy and consistency of 988 suicide and crisis lifeline call centers' personnel certifications, accreditations, quality assurance standards, and minimum training standards.

(d) Implementation of a cohesive statewide plan for 988 suicide and crisis lifeline call centers to achieve statewide interoperability with the 911 system and to provide individuals with rapid and direct access to the appropriate care.

Section 8. Present subsections (3) through (9) of section 397.427, Florida Statutes, are redesignated as subsections (2) through (8), respectively, and present subsections (2) and (5) of that section are amended, to read:

397.427 Medication-assisted treatment service providers; rehabilitation program; needs assessment and provision of services; persons authorized to issue takeout medication; unlawful operation; penalty.—

~~(2) The department shall determine the need for establishing providers of medication-assisted treatment services for opiate addiction.~~

~~(a) Providers of medication-assisted treatment services for opiate addiction may be established only in response to the department's determination and publication of need for additional medication treatment services.~~

~~(b) If needs assessment is required, the department shall~~

~~annually conduct the assessment and publish a statement of findings which identifies each substate entity's need.~~

~~(c) Notwithstanding paragraphs (a) and (b), the license for medication-assisted treatment programs for opiate addiction licensed before October 1, 1990, may not be revoked solely because of the department's determination concerning the need for medication-assisted treatment services for opiate addiction.~~

(4)~~(5)~~ ~~The department shall also determine the need for establishing medication-assisted treatment for substance use disorders other than opiate dependence.~~ Service providers within the publicly funded system shall be funded for provision of these services based on the availability of funds.

Section 9. Subsection (3) of section 397.68141, Florida Statutes, is amended to read:

397.68141 Contents of petition for involuntary treatment services.—A petition for involuntary services must contain the name of the respondent; the name of the petitioner; the relationship between the respondent and the petitioner; the name of the respondent's attorney, if known; and the factual allegations presented by the petitioner establishing the need for involuntary services for substance abuse impairment.

(3) If there is an emergency, the petition must also describe the respondent's exigent circumstances and include a request for an ex parte assessment and stabilization order that must be executed pursuant to s. 397.6818 ~~s. 397.68151~~.

Section 10. Section 916.111, Florida Statutes, is amended to read:

916.111 Training of mental health experts.—The evaluation of defendants for competency to proceed or for sanity at the

time of the commission of the offense shall be conducted in such a way as to ensure uniform application of the criteria enumerated in Rules 3.210 and 3.216, Florida Rules of Criminal Procedure. The department shall develop, and may contract with accredited institutions:

(1) To provide:

(a) A plan for training mental health professionals to perform forensic evaluations and to standardize the criteria and procedures to be used in these evaluations;

(b) Clinical protocols and procedures based upon the criteria of Rules 3.210 and 3.216, Florida Rules of Criminal Procedure; and

(c) Training for mental health professionals in the application of these protocols and procedures in performing forensic evaluations and providing reports to the courts. Training must include, but is not limited to, information on statutes and rules related to competency restoration, evidence-based practices, least restrictive treatment alternatives and placement options as described in s. 916.12(4)(c); and

(2) To compile and maintain the necessary information for evaluating the success of this program, including the number of persons trained, the cost of operating the program, and the effect on the quality of forensic evaluations as measured by appropriateness of admissions to state forensic facilities and to community-based care programs.

Section 11. Subsection (1) of section 916.115, Florida Statutes, is amended to read:

916.115 Appointment of experts.—

(1) The court shall appoint no more than three experts to

determine the mental condition of a defendant in a criminal case, including competency to proceed, insanity, involuntary placement, and treatment. The experts may evaluate the defendant in jail or in another appropriate local facility or in a facility of the Department of Corrections.

(a) The court ~~To the extent possible, The~~ appointed experts shall:

1. ~~have completed forensic evaluator training approved by the department, and each shall~~ Be a psychiatrist, licensed psychologist, or physician.

2. Have completed initial and ongoing forensic evaluator training, provided by the department.

3. If performing juvenile evaluations, complete annually, juvenile forensic competency evaluation training approved by the department.

(b) Existing evaluators shall complete department-provided continuing education training by July 1, 2026, to remain active on the list.

(c)~~(b)~~ The department shall maintain and annually provide the courts with a list of available mental health professionals who have completed the initial and annual approved training as experts.

Section 12. Paragraph (d) of subsection (4) of section 916.12, Florida Statutes, is amended to read:

916.12 Mental competence to proceed.—

(4) If an expert finds that the defendant is incompetent to proceed, the expert shall report on any recommended treatment for the defendant to attain competence to proceed. In considering the issues relating to treatment, the examining

expert shall specifically report on:

(d) The availability of acceptable treatment and, if treatment is available in the community, the expert shall so state in the report. In determining what acceptable treatments are available in the community, the expert shall, at a minimum, use current information or resources on less restrictive treatment alternatives, as described in paragraph (c) and those obtained from training and continuing education approved by the department.

The examining expert's report to the court shall include a full and detailed explanation regarding why the alternative treatment options referenced in the evaluation are insufficient to meet the needs of the defendant.

Section 13. Paragraph (a) of subsection (1) of section 394.674, Florida Statutes, is amended to read:

394.674 Eligibility for publicly funded substance abuse and mental health services; fee collection requirements.—

(1) To be eligible to receive substance abuse and mental health services funded by the department, an individual must be a member of at least one of the department's priority populations approved by the Legislature. The priority populations include:

(a) For adult mental health services:

1. Adults who have severe and persistent mental illness, as designated by the department using criteria that include severity of diagnosis, duration of the mental illness, ability to independently perform activities of daily living, and receipt of disability income for a psychiatric condition. Included

within this group are:

a. Older adults in crisis.

b. Older adults who are at risk of being placed in a more restrictive environment because of their mental illness.

c. Persons deemed incompetent to proceed or not guilty by reason of insanity under chapter 916.

d. Other persons involved in the criminal justice system.

e. Persons diagnosed as having co-occurring mental illness and substance abuse disorders.

2. Persons who are experiencing an acute mental or emotional crisis as defined in s. 394.67 ~~s. 394.67(18)~~.

Section 14. Paragraph (a) of subsection (3) of section 394.74, Florida Statutes, is amended to read:

394.74 Contracts for provision of local substance abuse and mental health programs.—

(3) Contracts shall include, but are not limited to:

(a) A provision that, within the limits of available resources, substance abuse and mental health crisis services, as defined in s. 394.67 ~~s. 394.67(4)~~, shall be available to any individual residing or employed within the service area, regardless of ability to pay for such services, current or past health condition, or any other factor;

Section 15. This act shall take effect July 1, 2025.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	SB 1578
INTRODUCER:	Senator Davis
SUBJECT:	Coverage for Mammograms and Supplemental Breast Cancer Screenings
DATE:	April 14, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Knudson	BI	**Favorable**
2.	Barr	McKnight	AHS	**Pre-meeting**
3.			FP	

I. Summary:

SB 1578 modifies required coverage for mammograms and supplemental breast cancer screenings in Florida. The bill requires the Agency for Health Care Administration (ACHA) to provide Medicaid coverage to female recipients who are aged 25 and over for one mammogram and one supplemental breast screening in certain circumstances.

Further, the bill modifies the coverage mandate for mammograms for the following types of insurance coverage:

- An individual accident and health insurance policy ("individual insurance policy"),
- A group, blanket, and franchise health insurance ("group insurance policy"), and
- A health maintenance organization (HMO) contract.

Such policies or contracts are amended to increase mandatory mammogram coverage and to require coverage for supplemental breast cancer screenings in specified circumstances, including coverage for additional risk factors than are covered under current law. The bill defines "supplemental breast cancer screening" to mean a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating physician for breast cancer screening in accordance with applicable American College of Radiology guidelines, which may include but is not limited to magnetic resonance imaging, ultrasound, and molecular breast imaging. The bill's coverage requirement of supplemental breast cancer screenings replaces the mandate that insurance policies and HMO contracts provide coverage for additional mammograms based on a physician's recommendation.

The relevant sections of current law are updated to conform to the revised coverage, and certain terms are defined in the relevant sections to clarify the scope of the coverage.

The bill will have an indeterminate, negative fiscal impact on state expenditures related to state employee insurance. The bill will have an indeterminate negative fiscal impact on private sector individuals and insurers. **See Section V., Fiscal Impact Statement**.

The bill takes effect July 1, 2025.

II. Present Situation:

Background

Rates of breast cancer vary among different groups of people. Rates vary between women and men and among people of different ethnicities and ages. Rates of breast cancer incidence (new cases) and mortality (death) are much lower among men than among women. The American Cancer Society made the following estimates regarding cancer among women in the U.S. during 2024:

- 310,720 new cases of invasive breast cancer (This includes new cases of primary breast cancer, but not breast cancer recurrences);
- 56,500 new cases of ductal carcinoma in situ (DCIS), a non-invasive breast cancer; and
- 42,250 breast cancer deaths.[1]

The estimates for men in the U.S. for 2024 were:

- 2,790 new cases of invasive breast cancer (This includes new cases of primary breast cancers, but not breast cancer recurrences); and
- 530 breast cancer deaths.[2]

Breast cancer is the second most common form of cancer diagnosed in women, and it is estimated that one in eight women will be diagnosed with breast cancer in her lifetime.[3] It accounts for 30 percent of all new female cancers in the United States each year.[4] The median age at which a woman is diagnosed is 62 with a very small percentage of women who are diagnosed under the age of 45.[5]

Risks and Risk Factors

There are no absolute ways to prevent breast cancer as there might be with other forms of cancer; however, there are some risk factors that may increase a woman's chances of receiving a diagnosis. Some risk factors that are out of an individual's control are:

- Being born female;
- Aging beyond 55;
- Inheriting certain gene changes;
- Having a family or personal history of breast cancer;
- Being of certain race or ethnicity;

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[1] *Cancer Facts & Figures*, pgs. 10-11, American Cancer Society - Cancer Facts & Figures 2024 (last visited Mar. 20, 2025).
[2] *Id.*
[3] American Cancer Society, *Key Statistics for Breast Cancer*, Breast Cancer Statistics | How Common Is Breast Cancer? | American Cancer Society (last visited Mar. 20, 2025).
[4] *Id.*
[5] *Id.*

- Being taller;
- Having dense breast tissue;
- Having certain benign breast conditions;
- Starting menstrual periods early, usually before age 12;
- Having radiation to the chest; and
- Being exposed to the drug, diethylstilbestrol.[6]

For many of the factors above, it is unclear why these characteristics make an individual more susceptible to a cancer diagnosis other than perhaps being female. However, men can and do receive breast cancer diagnoses, just in very small numbers. About one in every 100 breast cancers diagnosed in the United States is found in a man.[7]

Breast Cancer Screening

In Florida, an individual insurance policy, a group insurance policy, or a health maintenance contract issued, amended, delivered, or renewed in this state must provide coverage for at least the following:

- A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
- A mammogram every two years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendation.
- A mammogram every year for any woman who is 50 years of age or older.
- One or more mammograms a year, based upon a physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, having a history of biopsy-proven benign breast disease, having a mother, sister, or daughter who has or has had breast cancer, or a woman has not given birth before the age of 30.[8]

With respect to an individual insurance policy or a group insurance policy only, except for mammograms conducted more frequently than every 2 years for women between the ages of 40 to 50 years old, the coverage for mammograms described above only applies if the insured obtains a mammogram in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health.[9] The coverage for individual and group policies and contracts is subject to the deductible and coinsurance applicable to other benefits.[10]

However, mammography is only the initial step in early detection and, by itself, unable to diagnose cancer. A mammogram is an x-ray of the breast.[11] While screening mammograms are routinely performed to detect breast cancer in women who have no apparent symptoms,

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[6] American Cancer Society, *Breast Cancer Risk Factors You Cannot Change*- Breast Cancer Risk Factors You Can't Change | American Cancer Society (last visited Mar. 20, 2025).
[7] Centers for Disease Control and Prevention, *Breast Cancer in Men*- About Breast Cancer in Men | Breast Cancer | CDC (last visited Mar. 21, 2025).
[8] Sections 627.6418(1), 627.6613(2), and 641.31095(1), F.S.
[9] Sections 627.6418(2) and 627.6613(2), F.S.
[10] Sections 627.6418(2), 627.6613(2), and 641.31095(2), F.S.
[11] National Breast Cancer Foundation, *What Is The Difference Between A Diagnostic Mammogram And A Screening Mammogram?*, available at https://www.nationalbreastcancer.org/diagnostic-mammogram (last visited Mar. 21, 2025).

diagnostic mammograms are used after suspicious results on a screening mammogram or after some signs of breast cancer alert the physician to check the tissue.[12]

If a mammogram shows something abnormal, early detection of breast cancer requires diagnostic follow-up or additional supplemental imaging required to rule out breast cancer or confirm the need for a biopsy.[13] An estimated 12-16 percent of women screened with modern digital mammography require follow-up imaging.[14] Out-of-pocket costs are particularly burdensome on those who have previously been diagnosed with breast cancer, as diagnostic tests are recommended rather than traditional screening.[15] When breast cancer is detected early, the five-year relative survival rate is ninety-nine percent.[16]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[17] As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[18] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[19] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[20] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[21]

The Agency for Health Care Administration (AHCA) regulates the quality of care by health maintenance organizations (HMO) under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[22] As part of the certificate process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[23]

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[12] *Id.*
[13] Susan G. Komen Organization, *Breast Cancer Screening & Early Detection*, available at https://www.komen.org/breast-cancer/screening/ (last visited Mar. 21, 2025).
[14] *Id.*
[15] *Id.*
[16] National Breast Cancer Foundation, *3 Steps to Early Detection Guide*, available at 3 Steps to Early Detection - Breast Cancer Detection Guide (last visited Mar. 21, 2025).
[17] Section 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.
[18] Section 624.418, F.S.
[19] Section 624.316(1)(a), F.S.
[20] Section 624.318(2), F.S.
[21] Section 624.3161, F.S.
[22] Section 641.21(1), F.S.
[23] Section 641.495, F.S.

Florida's Medicaid Program[24]

Administration of the Program

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act (SSA). This authority includes establishing and maintaining a Medicaid state plan approved by the federal Centers for Medicare and Medicaid Services and maintaining any Medicaid waivers needed to operate the Florida Medicaid program as directed by the Florida Legislature.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs; it establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request a formal waiver of the requirements codified in the SSA. Federal waivers give states flexibility not afforded through their Medicaid state plan.

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

Mandatory Medicaid Coverage

Section 409.905, F.S., relating to mandatory Medicaid services, provides that the AHCA may make payments for delineated services, which are required of the state by Title XIX of the SSA. Currently, the Florida Medicaid program covers mammograms and other breast screening services under s. 409.905, F.S., and Rule 59G-4.240 of the Florida Administrative Code, which incorporates the Radiology and Nuclear Medicine Services Coverage Policy by reference. An eligible recipient must:

- Be enrolled in the Florida Medicaid program on the date of service,
- Meet the criteria of the policy, and
- Require medically necessary services.[25]

Mandatory services must not be duplicative.[26] Mammography screenings are covered at a frequency of one per year, per recipient.[27] No age limit or requirement is specified.[28] Any additional screening services are covered as listed on the associated Radiology Fee Schedule,

[24] Agency for Health Care Administration, *Senate Bill 1578 Bill Analysis*, (Mar. 20, 2025) (on file with the Senate Committee on Banking and Insurance)
[25] Agency for Health Care Administration, *Florida Medicaid: Radiology and Nuclear Medicine Services Coverage Policy*, p. 2-3, May 2019, available at 59G-4.240_Radiology_and_Nuclear_Medicine_Coverage_Policy_2019.pdf (last visited Mar. 21, 2025).
[26] Agency for Health Care Administration, *Florida Medicaid: Radiology and Nuclear Medicine Services Coverage Policy*, p. 2-3, May 2019, available at 59G-4.240_Radiology_and_Nuclear_Medicine_Coverage_Policy_2019.pdf (last visited Mar. 21, 2025).
[27] *Id.*
[28] *Id.*

which currently includes magnetic resonance imaging (MRI) of breast, molecular breast imaging of breast, ultrasound of breast, and digital breast tomosynthesis mammogram.[29] SMMC plans have the flexibility to cover service above and beyond the ACHA's coverage policies, but they may not be more restrictive than ACHA's policy, meaning they must cover these services as described in this section at a minimum.[30]

Patient Protection and Affordable Care Act

Essential Benefits

Under the Patient Protection and Affordable Care Act (PPACA),[31] all non-grandfathered health plans in the non-group and small-group private health insurance markets must offer a core package of health care services known as the essential health benefits (EHBs). While the PPACA does not specify the benefits within the EHB, it provides 10 categories of benefits and services that must be covered and it requires the Secretary of Health and Human Services to further define the EHB.[32]

The 10 EHB categories are:
- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitation and habilitation services.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

The PPACA requires each state to select its own reference benchmark plan as its EHB benchmark plan that all other health plans in the state use as a model. Beginning in 2020, states could choose a new EHB plan using one of three options, including: selecting another's state benchmark plan; replacing one or more categories of EHB benefits; or selecting a set of benefits that would become the State's EHB benchmark plan.[33] Florida selected its EHB plan before 2012 and has not modified that selection.[34]

[29] Agency for Health Care Administration, *Senate Bill 1578 Bill Analysis*, (Mar. 20, 2025) (on file with the Senate Committee on Banking and Insurance)
[30] *Id.*
[31] Patient Protection and Affordable Care Act of 2010. Pub. L. No. 111-141, as amended.
[32] 45 CFR 156.100. et seq.
[33] Centers for Medicare and Medicare Services, *Marketplace – Essential Health Benefits,* available at https://www.cms.gov/marketplace/resources/data/essential-health-benefits (last reviewed Mar. 21, 2025).
[34] Centers for Medicare and Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans,* Florida State Required Benefits, available at https://downloads.cms.gov/ (last viewed on Mar. 21, 2025).

State Employee Health Plan

For state employees who participate in the state employee benefit program, the Department of Management Services through the Division of State Group Insurance (DSGI) administers the state group health insurance program (Program).[35] The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.[36] To administer the program, DSGI contracts with third party administrators for self-insured plans, a fully insured HMO, and a pharmacy benefits manager for the state employees' self-insured prescription drug program, pursuant to s.110.12315, F.S. For the 2025 Plan Year, which began January 1, 2025, the HMO plans under contract with DSGI are Aetna, Capital Health Plan, and United Healthcare, and the preferred provider organization (PPO) plan is Florida Blue.[37]

Breast Cancer Screening Coverage

Currently, the Program covers 100 percent of the costs of screening, preventive mammograms, (consistent with federal requirements related to essential health benefits coverage). Out of pocket costs, such as copayments, may vary for supplemental and diagnostic imaging based on the enrollee's plan and the provider selected.

Legislative Proposals for Mandated Health Benefit Coverage

Any person or organization proposing legislation which would mandate health coverage or the offering of health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, must submit to the AHCA and the legislative committees having jurisdiction a report which assesses the social and financial impacts of the proposed coverage.[38] Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage, to the extent that information is available, include:

- To what extent is the treatment or service generally used by a significant portion of the population?
- To what extent is the insurance coverage generally available?
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment?
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship?
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service?

[35] Section 110.123, F.S.
[36] A section 125 cafeteria plan is a type of employer offered, flexible health insurance plan that provides employees a menu of pre-tax and taxable qualified benefits to choose from, but employees must be offered at least one taxable benefit such as cash, and one qualified benefit, such as a Health Savings Account.
[37] Department of Management Services, Division of State Group Insurance, *2024 Open Enrollment Brochure for Active State Employee Participants,* available at https://www.mybenefits.myflorida.com/beta_-_open_enrollment (last visited Mar. 21, 2025).
[38] Section 624.215(2), F.S.

- To what extent will the coverage increase the appropriate uses of the treatment or service?
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service?
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders?
- The impact of this coverage on the total cost of health care.[39]

To date, such a report has not been received by the Senate Committee on Banking and Insurance.

III. Effect of Proposed Changes:

The bill amends certain Medicaid and minimum insurance coverage for mammograms and supplemental breast cancer screenings to apply to younger women and modifies risk factors.

Section 1 requires, subject to availability, limitations or directions of funds, the Agency for Health Care Administration (AHCA) to provide the following specified annual coverage to a woman who is aged 25 years or older and enrolled in the Florida Medicaid Program:

- One mammogram to detect the presence of breast cancer.
- One supplemental breast cancer screening to detect breast cancer if:
  - The woman's mammogram demonstrates that the woman has dense breast based on specified imaging standards.
  - The woman is at increased risk of breast cancer due to a personal or family history of breast cancer, a personal history of biopsy-proven benign breast disease, ancestry, genetic predisposition, not having given birth before the age of 30, and other reasons as determined by the woman's health care provider.

The AHCA must seek any required federal approval to implement these provisions.

The bill also defines the following terms in the Florida Medicaid laws:

- "Mammogram" means "an image of a radiologic examination used to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the X-ray picture of the breast captured using equipment dedicated specifically for mammography, including, but not limited to, the X-ray tube, filter, compression device, screens, film, and cassettes. The radiologic examination must include two views of each breast. The term also includes images from digital breast tomosynthesis and the professional interpretation of images from any mammography equipment but does not include any diagnostic mammography image."
- "Supplemental breast cancer screening" means "a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating health care provider for breast cancer screening in accordance with applicable American College of Radiology guidelines, which examination includes, but is not limited to, magnetic resonance imaging, ultrasound, and molecular breast imaging."

Sections 2, 3, and 4 modifie ss. 627.6418, 627.6613, and 641.31095, F.S., relating to an individual insurance policy; a group insurance policy; and a health maintenance organization contract, respectively, to revise the state's coverage mandates for mammograms. For any woman aged 25 or older, the policy or contract must provide coverage for one mammogram and must

[39] Section 624.215(2)(a)-(l), F.S.

also cover one supplemental breast cancer screening per year, based upon a physician's recommendation if the woman is a risk for breast cancer because of dense breast tissue, a personal or family history of breast cancer, a personal history of biopsy-proven benign breast disease, ancestry, genetic predisposition, the woman has not given birth before age 30, or because of other reasons determined by the woman's physician.

The bill makes the following changes to current law:

- Lowers the minimum age for any mandatory coverage by ten years (i.e. from 35 years old to 25 years old).
- Increases coverage for any woman who is between 35 and 40 years old to cover mammograms, rather than a single baseline mammogram.
- Clarifies that a mammogram for any woman covered under the provision includes a digital breast tomosynthesis mammogram.
- Increases the frequency of coverage for any woman who is between the ages of 40 and 50 years old to one mammogram per year, rather than one every two years or more frequently based on the patient's physician's recommendation.
- Based upon a physician's recommendation, requires such policies to cover one supplemental breast cancer screening per year, rather than one or more mammograms a year provided under current law, based on certain risk factors which are modified in the bill to include the following additional risk factors:
    - Dense breast tissue, as evidenced by the woman's mammogram and standards prescribed by the American College of Radiology.
    - A personal or family history of breast cancer.
    - A personal history of biopsy-proven benign breast disease.
    - Ancestry.
    - Genetic predisposition.
    - Other reasons as determined by the woman's physician.

Further, the risk factor of having a mother, sister, or daughter who has or has had breast cancer is removed because it overlaps with the new broader factor of having a personal or family history of breast cancer. The risk factor of having a history of biopsy-proven benign breast disease is clarified to specify that the history must be a "personal" one.

The bill defines "supplemental breast cancer screening" for purposes of the section to mean "a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating health care provider for breast cancer screening in accordance with applicable American College of Radiology guidelines, which examination includes, but is not limited to, magnetic resonance imaging, ultrasound, and molecular breast imaging."

With respect to **sections 2 and 3 only** (relating to an individual insurance policy and a group insurance policy), the bill also modifies current law to require coverage of all mammograms and applicable supplement breast cancer screenings obtained in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health, rather than only certain specified mammograms, and such coverage is subject to deductibles and coinsurance provisions applicable to outpatient visits.

Section 5 provides that the bill is effective July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The fiscal impact on the private sector is indeterminate. Based on the additional coverage provided under the bill, a negative fiscal may impact the private sector if premiums are raised; however, the private sector may get earlier access to diagnosis and treatment.

Insurers may incur indeterminate administrative costs for implementing provisions of the bill. Any increased costs which the insurers may incur due to the enhanced coverage requirement within the bill would likely be passed on to insureds. However, if the bill increases early detection of breast cancer, it may lead to more successful health outcomes for women.

C. Government Sector Impact:

The bill would have minimal operational impact on the Agency for Health Care Administration and the Florida Medicaid program. Required updates of rules to conform with the provisions of the bill can be covered within existing staff and resources. The bill would not have any fiscal impact on the agency to the extent that mammograms and

supplemental breast cancer screenings required in the bill are already covered by Florida Medicaid.[40]

The Division of State Group Insurance may incur an indeterminate negative fiscal impact to cover state employees for the additional coverage required in the bill.

VI. Technical Deficiencies:

Regarding the Florida Medicaid program coverage, the basis for a supplemental breast cancer screening that provides on lines 70-71 "other reasons as determined by the woman's health care provider" should specify that the other reason must be a "medical" reason.

VII. Related Issues:

Federal authority is not required to implement the requirements of the bill because Florida Medicaid already covers the services prescribed in the bill.[41]

Rule 59G-4.240, F.A.C., Radiology and Nuclear Medicine Services Coverage Policy, would need to be amended to conform to the provisions of the bill.[42]

The effective date of July 1, 2025, in sections 2, 3, 4, and 5 does not coincide with the typical January 1 start of the plan year for commercial and state group plans.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6418, 627.6613, and 641.31095.

The bill creates section 409.904 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[40] Agency for Health Care Administration, *Senate Bill 1578 Bill Analysis*, (Mar. 20, 2025) (on file with the Senate Committee on Banking and Insurance)
[41] *Id.*
[42] *Id.*

By Senator Davis

5-00578-25 20251578__

A bill to be entitled

An act relating to coverage for mammograms and supplemental breast cancer screenings; creating s. 409.9064, F.S.; defining the terms "mammogram" and "supplemental breast cancer screening"; requiring the Agency for Health Care Administration to provide Medicaid coverage for annual mammograms and supplemental breast cancer screenings for certain women meeting specified criteria, subject to the availability of funds and any limitations or directions the Legislature provides in the General Appropriations Act; requiring the agency to seek federal approval, if needed, to implement specified provisions; amending ss. 627.6418, 627.6613, and 641.31095, F.S.; defining the term "supplemental breast cancer screening"; revising coverage for mammograms under certain individual accident and health insurance policies, certain group, blanket, and franchise accident and health insurance policies, and certain health maintenance contracts, respectively; requiring coverages for supplemental breast cancer screenings under such policies and contracts under certain circumstances; revising applicability; providing an effective date.

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

Section 1. Section 409.9064, Florida Statutes, is created to read:

5-00578-25 20251578__

409.9064 Coverage for mammograms and supplemental breast cancer screenings.—

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

(a) "Mammogram" means an image of a radiologic examination used to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the X-ray picture of the breast captured using equipment dedicated specifically for mammography, including, but not limited to, the X-ray tube, filter, compression device, screens, film, and cassettes. The radiologic examination must include two views of each breast. The term also includes images from digital breast tomosynthesis and the professional interpretation of images from any mammography equipment but does not include any diagnostic mammography image.

(b) "Supplemental breast cancer screening" means a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating health care provider for breast cancer screening in accordance with applicable American College of Radiology guidelines, which examination includes, but is not limited to, magnetic resonance imaging, ultrasound, and molecular breast imaging.

(2) Subject to the availability of funds and subject to any limitations or directions provided in the General Appropriations Act, the agency shall provide coverage for the following every year for a Medicaid recipient who is a woman 25 years of age or older:

(a) One mammogram to detect the presence of breast cancer.

(b) One supplemental breast cancer screening to detect the presence of breast cancer if:

1. Based on the breast imaging reporting and data system

established by the American College of Radiology, the woman's mammogram demonstrates that the woman has dense breast tissue; or

2. The woman is at an increased risk of breast cancer due to any of the following:

a. A personal or family history of breast cancer.

b. A personal history of biopsy-proven benign breast disease.

c. Ancestry.

d. Genetic predisposition.

e. Not having given birth before the age of 30.

f. Other reasons as determined by the woman's health care provider.

(3) The agency shall seek federal approval, if needed, for the implementation of this section.

Section 2. Section 627.6418, Florida Statutes, is amended to read:

627.6418 Coverage for mammograms and supplemental breast cancer screenings.—

(1) As used in this section, the term "supplemental breast cancer screening" means a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating health care provider for breast cancer screening in accordance with applicable American College of Radiology guidelines, which examination includes, but is not limited to, magnetic resonance imaging, ultrasound, and molecular breast imaging.

(2) An accident or health insurance policy issued, amended, delivered, or renewed in this state on or after July 1, 2025,

must provide coverage for at least the following for any woman who is 25 years of age or older:

(a) One ~~A baseline~~ mammogram a year, including a digital breast tomosynthesis mammogram ~~for any woman who is 35 years of age or older, but younger than 40 years of age~~.

(b) ~~A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendation.~~

~~(c) A mammogram every year for any woman who is 50 years of age or older.~~

~~(d)~~ One supplemental breast cancer screening ~~or more mammograms~~ a year, based upon a physician's recommendation, if the ~~for any~~ woman ~~who~~ is at risk for breast cancer because of dense breast tissue, as demonstrated by the woman's mammogram and based on the breast imaging reporting and data system established by the American College of Radiology; because of a personal or family history of breast cancer;~~,~~ because of ~~having~~ a personal history of biopsy-proven benign breast disease; because of ancestry; because of genetic predisposition;~~, because of having a mother, sister, or daughter who has or has had breast cancer, or~~ because the ~~a~~ woman has not given birth before the age of 30; or because of other reasons as determined by the woman's physician.

(3)~~(2)~~ ~~Except as provided in paragraph (1)(b), for mammograms done more frequently than every 2 years for women 40 years of age or older but younger than 50 years of age,~~ The coverage required by subsection (2) ~~(1)~~ applies~~, with or without a physician prescription,~~ if the insured obtains a mammogram and, if applicable, a supplemental breast cancer screening in an

office, facility, or health testing service that uses radiological equipment registered with the Department of Health for breast cancer screening. The coverage is subject to the deductible and coinsurance provisions applicable to outpatient visits~~,~~ and is also subject to all other terms and conditions applicable to other benefits. This section does not affect any requirements or prohibitions relating to who may perform, analyze, or interpret a mammogram or the persons to whom the results of a mammogram may be furnished or released.

(4)~~(3)~~ This section does not apply to disability income, specified disease, or hospital indemnity policies.

(5)~~(4)~~ Every insurer subject to the requirements of this section shall make available to the policyholder as part of the application, for an appropriate additional premium, the coverage required in this section without such coverage being subject to the deductible or coinsurance provisions of the policy.

Section 3. Section 627.6613, Florida Statutes, is amended to read:

627.6613 Coverage for mammograms and supplemental breast cancer screenings.—

(1) As used in this section, the term "supplemental breast cancer screening" means a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating physician for breast cancer screening in accordance with applicable American College of Radiology guidelines, which examination includes, but is not limited to, magnetic resonance imaging, ultrasound, and molecular breast imaging.

(2) A group, blanket, or franchise accident or health insurance policy issued, amended, delivered, or renewed in this

state on or after July 1, 2025, must provide coverage for at least the following for any woman who is 25 years of age or older:

(a) One ~~A baseline~~ mammogram a year, including a digital breast tomosynthesis mammogram ~~for any woman who is 35 years of age or older, but younger than 40 years of age~~.

(b) ~~A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendation.~~

~~(c) A mammogram every year for any woman who is 50 years of age or older.~~

~~(d)~~ One supplemental breast cancer screening ~~or more mammograms~~ a year, based upon a physician's recommendation, if the ~~for any~~ woman ~~who~~ is at risk for breast cancer because of dense breast tissue as demonstrated by the woman's mammogram and based on the breast imaging reporting and data system established by the American College of Radiology; because of a personal or family history of breast cancer;~~,~~ because of ~~having~~ a personal history of biopsy-proven benign breast disease; because of ancestry; because of genetic predisposition;~~, because of having a mother, sister, or daughter who has or has had breast cancer, or~~ because the ~~a~~ woman has not given birth before the age of 30; or because of other reasons as determined by the woman's physician.

(3)~~(2) Except as provided in paragraph (1)(b), for mammograms done more frequently than every 2 years for women 40 years of age or older but younger than 50 years of age,~~ The coverage required by subsection (2) ~~(1)~~ applies~~, with or without a physician prescription,~~ if the insured obtains a mammogram

and, if applicable, a supplemental breast cancer screening in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health for breast cancer screening. The coverage is subject to the deductible and coinsurance provisions applicable to outpatient visits~~,~~ and is also subject to all other terms and conditions applicable to other benefits. This section does not affect any requirements or prohibitions relating to who may perform, analyze, or interpret a mammogram or the persons to whom the results of a mammogram may be furnished or released.

(4)~~(3)~~ Every insurer referred to in subsection (2) ~~(1)~~ shall make available to the policyholder as part of the application, for an appropriate additional premium, the coverage required in this section without such coverage being subject to the deductible or coinsurance provisions of the policy.

Section 4. Section 641.31095, Florida Statutes, is amended to read:

641.31095 Coverage for mammograms and supplemental breast cancer screenings.—

(1) As used in this section, the term "supplemental breast cancer screening" means a clinically appropriate examination, in addition to a mammogram, deemed medically necessary by a treating physician for breast cancer screening in accordance with applicable American College of Radiology guidelines, which examination includes, but is not limited to, magnetic resonance imaging, ultrasound, and molecular breast imaging.

(2) Every health maintenance contract issued or renewed on or after July 1, 2025, must ~~January 1, 1996, shall~~ provide coverage for at least the following for any woman who is 25

years of age or older:

(a) One ~~A baseline~~ mammogram a year, including a digital breast tomosynthesis mammogram ~~for any woman who is 35 years of age or older, but younger than 40 years of age~~.

(b) ~~A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendations.~~

~~(c) A mammogram every year for any woman who is 50 years of age or older.~~

~~(d)~~ One supplemental breast cancer screening ~~or more mammograms~~ a year, based upon a physician's recommendation, if the ~~for any~~ woman ~~who~~ is at risk for breast cancer because of dense breast tissue as demonstrated by the woman's mammogram and based on the breast imaging reporting and data system established by the American College of Radiology; because of a personal or family history of breast cancer;~~,~~ because of ~~having~~ a personal history of biopsy-proven benign breast disease; because of ancestry; because of genetic predisposition;~~, because of having a mother, sister, or daughter who has had breast cancer, or~~ because the ~~a~~ woman has not given birth before the age of 30; or because of other reasons as determined by the woman's physician.

(3)~~(2)~~ The coverage required by this section is subject to the deductible and copayment provisions applicable to outpatient visits~~,~~ and is also subject to all other terms and conditions applicable to other benefits. A health maintenance organization shall make available to the subscriber as part of the application, for an appropriate additional premium, the coverage required in this section without such coverage being subject to

any deductible or copayment provisions in the contract.

Section 5. This act shall take effect July 1, 2025.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	CS/SB 1602
INTRODUCER:	Health Policy Committee and Senator Harrell
SUBJECT:	Health Care Patient Protection
DATE:	April 14, 2025
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1602 requires each hospital with an emergency department (ED) to develop and implement policies and procedures for pediatric patient care in the ED. Additionally, each such hospital ED must designate a pediatric emergency care coordinator and conduct the National Pediatric Readiness Assessment (NPRA) within a certain time frame.

The bill also requires the Agency for Health Care Administration to incorporate the needs of pediatric and neonatal patients in rules requiring an emergency management plan, to adopt rules that establish minimum standards for pediatric patient care in hospital EDs, and to collect the results of the NPRA and publish the overall assessment score for each hospital ED and provide a comparison to the national average score.

The bill has no fiscal impact on state expenditures or revenues. The bill will have an indeterminate, negative fiscal impact on hospitals with EDs. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

II. Present Situation:

Hospital Licensure

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under ch. 395, F.S., and the general licensure provisions of part II, of ch. 408, F.S. In Florida, emergency departments (ED) are either located in a hospital or on separate premises of a licensed hospital. Any licensed hospital which has a dedicated ED may provide emergency services in a location separate from the hospital's main premises, known as a hospital-based off-campus emergency department.[1]

Current law requires each hospital with an ED to screen, examine, and evaluate a patient who presents to the ED to determine if an emergency medical condition exists and, if it does, provide care, treatment, or surgery to relieve or eliminate the emergency medical condition.[2] Each hospital with an ED must provide emergency services and care[3] 24 hours a day and must have at least one physician on-call and available within 30 minutes.[4]

Inventory of Hospital Emergency Services

Each hospital offering emergency services and care must report to the AHCA the services which are within the service capability of the hospital.[5] The AHCA is required to maintain an inventory of hospitals with emergency services, including a list of the services within the service capability of the hospital, to assist emergency medical services providers and the general public in locating appropriate emergency medical care.[6] If a hospital determines it is unable to provide a service on a 24 hour per day, 7 day per week, basis, either directly or indirectly through an arrangement with another hospital, the hospital must request a service exemption from the AHCA.[7]

Policies and Procedures

Each hospital offering emergency services and care is required to maintain written policies and procedures specifying the scope and conduct of their emergency services. The policies and procedures must be approved by the organized medical staff, reviewed at least annually, and must include:

- A process to designate a physician to serve as the director of the ED;

[1] Section 395.002(13), F.S.
[2] Section 395.1041, F.S.
[3] Section 395.002(9), F.S., "emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.
[4] Fla. Admin. Code R. 59A-3.255(6)(e)(2014).
[5] Section 395.1041(2), F.S.
[6] Medical services listed in the inventory include: anesthesia; burn; cardiology; cardiovascular surgery; colon & rectal surgery; emergency medicine; endocrinology; gastroenterology; general surgery; gynecology; hematology; hyperbaric medicine; internal medicine; nephrology; neurology; neurosurgery; obstetrics; ophthalmology; oral/maxilla-facial surgery; orthopedics; otolaryngology; plastic surgery; podiatry; psychiatry; pulmonary medicine; radiology; thoracic surgery; urology; and vascular surgery.
[7] Fla. Admin. Code R. 59A-3.255(4)(2014).

- A written description of the duties and responsibilities of all other health care personnel providing care within the ED;
- A planned formal training program on emergency access laws for all health care personnel working in the ED; and
- A control register to identify all persons seeking emergency care.[8]

Current law does not require EDs to have pediatric-specific policies and procedures.

Equipment and Supplies

Each hospital ED is required to provide diagnostic radiology services and clinical laboratory services and must ensure that an adequate supply of blood is available at all times. Hospitals EDs are also required to have certain equipment available for immediate use at all times, including:

- Oxygen and means of administration;
- Mechanical ventilatory assistance equipment, including airways, manual breathing bags, and ventilators;
- Cardiac defibrillators with synchronization capability;
- Respiratory and cardiac monitoring equipment;
- Thoracentises and closed thoracotomy sets;
- Tracheostomy or cricothyrotomy sets;
- Tourniquets;
- Vascular cutdown sets;
- Laryngoscopes and endotracheal tubes;
- Urinary catheters with closed volume urinary systems;
- Pleural and pericardial drainage sets;
- Minor surgical instruments;
- Splinting devices;
- Emergency obstetrical packs;
- Standard drugs as determined by the facility;
- Common poison antidotes;
- Syringes, needles, and surgical supplies;
- Parenteral fluids and infusion sets;
- Refrigerated storage for biologicals and other supplies; and
- Stable examination tables.[9]

Currently, there are no pediatric-specific equipment or supply standards for EDs.

Comprehensive Emergency Management Plans

All hospitals are required to develop and adopt a comprehensive emergency management plan for emergency care during an internal or external disaster or an emergency.[10] Each hospital must review, update, and submit its plans annually to the respective county office of emergency

[8] Fla. Admin. Code R. 59A-3.255(6)(e)(2014).
[9] Fla. Admin. Code R. 59A-3.255(6)(g)(2014).
[10] Section 395.1055(1)(c), F.S.

management. A hospital's comprehensive emergency management plan must include the following:

- Provisions for the management of staff, including the distribution and assignment of responsibilities and functions;
- Education and training of personnel in carrying out their responsibilities in accordance with the adopted plan;
- Information about how the hospital plans to implement specific procedures outlined in the plan;
- Precautionary measures, including voluntary cessation of hospital admissions, to be taken in preparation and response to warnings of inclement weather, or other potential emergency conditions;
- Provisions for the management of patients, including the discharge of patients in the event of an evacuation order;
- Provisions for coordinating with other hospitals;
- Provisions for the individual identification of patients, including the transfer of patient records;
- Provisions to ensure that relocated patients arrive at designated hospitals;
- Provisions to ensure that medication needs will be reviewed and advance medication for relocated patients will be forwarded to the appropriate hospitals;
- Provisions for essential care and services for patients who may be relocated to the facility during a disaster or an emergency, including staffing, supplies, and identification of patients;
- Provisions for the management of supplies, communications, power, emergency equipment, and security;
- Provisions for coordination with designated agencies including the Red Cross and the county emergency management office; and
- Plans for the recovery phase of the operation.[11]

Current law does not require hospitals to include any pediatric-specific provisions in their comprehensive emergency management plans.

Pediatric Care in Hospital Emergency Departments

Children represent approximately 25 percent of all ED visits in the U.S. each year.[12] According to a recent study conducted to evaluate the association between ED pediatric readiness and in-hospital mortality, pediatric patient deaths are 60 percent to 76 percent less likely to occur in an ED with high pediatric readiness. The study included 796,937 pediatric patient visits in 983 EDs over a six-year period (January 1, 2012, through December 31, 2017).

The study used the results of the 2013 National Pediatric Readiness Project Assessment to categorize each hospital ED in one of four levels of pediatric readiness (first quartile 0-58, second quartile 59-72, third quartile 73-87, and fourth quartile 88-100). Hospital EDs with an

[11] Fla. Admin. Code R. 59A-3.078(2014).
[12] Remick KE, Hewes HA, Ely M, et al. National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic. *JAMA Netw Open.* 2023. *available at* National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic | Pediatrics | JAMA Network Open | JAMA Network, (last visited Mar. 28, 2025).

Assessment score of 88-100 were categorized as having high pediatric readiness. The study also concluded that if all 983 EDs had high pediatric readiness, an estimated 1,442 pediatric deaths may have been prevented.[13]

General hospital EDs (nonchildren's hospitals) primarily treat adults and may not be prepared to treat children because of low pediatric patient volume.[14] More than 97 percent of EDs caring for children are general hospital EDs, accounting for 82 percent of pediatric ED visits. Most of these hospitals see less than 15 pediatric patients per day.[15] Therefore, according to a joint policy statement issued by the American Academy of pediatrics (AAP), the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA), "it is imperative that all hospital EDs have the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children."[16]

The 2009 joint policy statement also included guidelines for care of children in the emergency department. In 2012, the Emergency Medical Services for Children (EMSC) Program, under the U.S. Department of Health and Human Services, used the guidelines to launch the National Pediatric Readiness Project, in partnership with the AAP, ACEP, and ENA.[17]

The National Pediatric Readiness Project

The National Pediatric Readiness Project (NPRP) is a quality improvement initiative offering state partnership grants to state governments and accredited schools of medicine to expand and improve emergency medical services for children in hospital EDs.[18] The NPRP measures the performance of hospital EDs based on the following four metrics and includes program goals for each.[19]

- Pediatric Readiness Recognition Programs – Program Goal: To increase the percent of hospitals with an ED recognized through a statewide, territorial, or regional standardized program that are able to stabilize and manage pediatric emergencies.
- Pediatric Emergency Care Coordinators – Program Goal: To increase the percent of hospitals with an ED that have a designated nurse, physician, or both who coordinates pediatric emergency care.

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[13] Newgard CD, Lin A, Malveau S, et al. *Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care*. JAMA Network (January, 2023) *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800400 (last visited Mar. 28, 2025).
[14] *Id.*
[15] The National Pediatric Readiness Project, Pediatric Readiness Saves Lives, *available at* https://media.emscimprovement.center/documents/EMS220628_ReadinessByTheNumbers_220830_ZekNYVF.pdf (last visited Mar. 28, 2025).
[16] American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement--guidelines for care of children in the emergency department (Oct. 2009), *available at* https://doi.org/10.1542/peds.2009-1807 (last visited Mar. 28, 2025).
[17] *Id.*
[18] The program is also used to improve emergency medical care for children in prehospital settings and to advance family partnerships and leadership in efforts to improve EMSC systems of care, *see* https://www.grants.gov/search-results-detail/340371 (last visited Mar. 28, 2025).
[19] EMSC Innovation and Improvement Center, Performance Measures, *available at* https://emscimprovement.center/programs/partnerships/performance-measures/ (last visited Mar. 28, 2025).

- Disaster Plan Resources – Program Goal: To increase the percent of hospitals with an ED that have a disaster plan that addresses the needs of children.
- Weigh and Record Children's Weight in Kilograms – Program Goal: To increase the percent of hospitals with an ED that weigh and record children in kilograms.

The NPRP particularly focuses on weighing and recording children's weight in kilograms to avoid medication errors. Product labeling for medications with weight-based dosing utilize the metric system. Converting from pounds to kilograms is an error-prone process and can double the number of dosing errors made. Pediatric and neonatal patients are at greater risk for adverse drug events because they are more vulnerable to the effects of an error.[20]

The National Pediatric Readiness Assessment

Emergency department performance is measured based on the NPRA,[21] a voluntary survey accessed via invitation from the NPRP. The NPRP has conducted two nationwide assessments. The first NPRA occurred in 2013 and the second was in 2021. According to current Program plans, the expectation is that the NPRA will occur every five years, so the next assessment will be in 2026.[22]

Not all hospitals choose to participate in the NPRA. Florida participation rates (58 percent) are below the national average (71 percent), and dropped from 2013 to 2021 (from 61 to 58 percent). Additionally, while over the national average, Florida hospital readiness scores dropped on average between 2013 (78) and 2021 (75).[23, 24]

Florida Emergency Medical Services for Children State Partnership Program

The Florida Emergency Medical Services for Children (EMSC) State Partnership Program[25] (program) is a quality improvement initiative administered by the University of Florida College of Medicine — Jacksonville, and is funded by a state partnership grant from the national EMSC

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[20] Emergency Nurses Association, *Weighing all Patients in Kilograms* (2020), *available a*t https://www.pedsnurses.org/assets/docs/Engage/Position-Statements/Weighing%20All%20Patients%20in%20Kilograms%20Final%20Web.pdf *see also* National Coordinating Council for Medication Error Reporting and Prevention, *Recommendations to Weigh Patients and Document Metric Weights to Ensure Accurate Medication Dosing* (Oct. 2018), *available at* https://www.nccmerp.org/recommendations-weigh-patients-and-document-metric-weights-ensure-accurate-medication-dosing-adopted (both last visited Mar. 28, 2025).

[21] National Pediatric Readiness Project, Pediatric Readiness Assessment, *available at* https://www.pedsready.org/home_docs/PedsReady%20Survey-OA%20Assessment.pdf (last visited Mar. 28, 2025).

[22] Emergency Medical Services for Children, National Pediatric Readiness Project Assessment, *available at* https://emscdatacenter.org/sp/pediatric-readiness/national-pediatric-readiness-project-nprp-assessment/ (last visited Mar. 28, 2025).

[23] Florida versus National Pediatric Readiness Project Results from 2013 Survey, *available at* https://www.floridahealth.gov/provider-and-partner-resources/emsc-program/_documents/fl-pediatricreadiness-summary091013.pdf (last visited Mar. 28, 2025).

[24] Florida Versus National Pediatric Readiness Project Results from 2021 Survey, *available at* https://emlrc.org/wp-content/uploads/National-Pediatric-Readiness-Assessment-2021-Results_07.19.2023_Final.pdf (last visited Mar. 28, 2025).

[25] Florida Emergency Medical Services for Children State Partnership Program (Florida PEDREADY), *available at* https://flemsc.emergency.med.jax.ufl.edu/ (last visited Mar. 28, 2025).

Program.[26] The purpose of the program is to expand and improve emergency medical services for children who need treatment for trauma or critical care by partnering with EDs, emergency medical service agencies, and disaster preparedness organizations to enhance pediatric readiness. The program provides outreach and information to hospital EDs to help improve their pediatric readiness by, among other things, increasing awareness of, and participation in, the NPRP Assessment.

III. Effect of Proposed Changes:

Section 1 amends s. 395.1012, F.S., to require each hospital with an emergency department (ED) to:

- Develop and implement policies and procedures for pediatric patient care in the ED which reflect evidence-based best practices relating to, at a minimum:
  - Triage.
  - Measuring and recording vital signs.
  - Weighing and recording weights in kilograms.
  - Calculating medication dosages.
  - Use of pediatric instruments.
- Conduct training at least annually on the policies and procedures developed under this subsection. The training must include, at a minimum:
  - The use of pediatric instruments, as applicable to each licensure type, using clinical simulation as defined in s. 464.003, F.S.
  - Drills that simulate emergency situations. Each ED must conduct drills at least annually.
- Designate a pediatric emergency care coordinator. The pediatric emergency care coordinator must be a physician or a physician assistant licensed under ch. 458 or ch. 459, F.S., a nurse licensed under ch. 464, F.S., or a paramedic licensed under ch. 401, F.S. The pediatric emergency care coordinator is responsible for implementation of and ensuring fidelity to the policies and procedures adopted as required above.
- Conduct the National Pediatric Readiness Assessment (NPRA) developed by the National Pediatric Readiness Project (NPRP), in accordance with timelines established by the NPRP. The bill also authorizes each hospital with an ED to conduct the NPRP's Open Assessment during a year in which the NPRA is not conducted.

Section 2 amends s. 395.1055, F.S., to require the Agency for Health Care Administration (AHCA) to:

- Incorporate the needs of pediatric and neonatal patients in rules requiring an emergency management plan for hospitals and ambulatory surgical centers; and
- Adopt rules, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, that establish minimum standards for pediatric patient care in hospital EDs, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies.

Section 3 amends s. 408.05, F.S., to require the AHCA to:

[26] EMSC Innovation and Improvement Center, EMSC State Partnership Grants Database, Florida – State Partnership, April 1, 2023 – March 31, 2027, *available at* https://emscimprovement.center/programs/grants/236/florida-state-partnership-20230401-20270331-emsc-state-partnership/ (last visited Mar. 28, 2025).

- Collect the results of the NPRA from the Florida Emergency Medical Services for Children State Partnership Program by December 31, 2026, and each December 31 during a year in which the NPRA is conducted; and
- By April 1, 2027, and each April 1 following a year in which the NPRA is conducted, publish the overall assessment score for each hospital ED and provide a comparison to the national average score when it becomes available. The bill specifies that only one overall assessment score per hospital, per year, may be collected and published and the comparison must be to the most recently published score.

Section 4 provides that the bill takes effect July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will have an indeterminate, negative fiscal impact on hospitals related to incorporating additional requirements specific to pediatric readiness in the hospitals' emergency departments.[27]

[27]Agency for Health Care Administration, *Senate Bill 1602 Analysis* (Mar. 5, 2025) (on file with the Senate Appropriations Committee on Health and Human Services).

C. Government Sector Impact:

The bill requires the Agency for Health Care Administration to collect and publish online specific data collected from hospitals. These requirements will be managed within existing contracts and resources.[28]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.1012, 395.1055, and 408.05.

IX. Additional Information:

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

CS by Health Policy on April 1, 2025:
The CS no longer requires emergency departments (ED) to submit results of the National Pediatric Readiness Assessment (NPRA) to the Agency for Health Care Administration (AHCA) and instead requires the AHCA to obtain the results from the Florida Emergency Medical Services for Children State Partnership Program. Additionally, the bill authorizes EDs to conduct the National Pediatric Readiness Programs' Open Assessment during years when the NPRA is not conducted and prohibits the AHCA from collecting and publishing more than one assessment score per year for comparison purposes.

B. Amendments:

None.

[28]Agency for Health Care Administration, *Senate Bill 1602 Analysis* (Mar. 5, 2025) (on file with the Senate Appropriations Committee on Health and Human Services).

By the Committee on Health Policy; and Senator Harrell

588-03191-25 20251602c1

A bill to be entitled

An act relating to health care patient protection; amending s. 395.1012, F.S.; requiring hospital emergency departments to develop and implement policies and procedures, conduct training, record weights in a certain manner, designate a pediatric emergency care coordinator, and conduct specified assessments; authorizing a hospital with an emergency department to conduct the National Pediatric Readiness Project's Open Assessment under certain circumstances; amending s. 395.1055, F.S.; requiring the Agency for Health Care Administration to adopt certain rules for comprehensive emergency management plans; requiring the agency, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, to establish minimum standards for pediatric patient care in hospital emergency departments; amending s. 408.05, F.S.; requiring the agency to collect and publish the results of specified assessments submitted by hospitals by specified dates; providing requirements for the collection and publication of the hospitals' assessment scores; providing an effective date.

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

Section 1. Subsections (5) and (6) are added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

588-03191-25 20251602c1

(5)(a) Each hospital with an emergency department must:

1. Develop and implement policies and procedures for pediatric patient care in the emergency department which reflect evidence-based best practices relating to, at a minimum:

a. Triage.

b. Measuring and recording vital signs.

c. Weighing and recording weights in kilograms.

d. Calculating medication dosages.

e. Use of pediatric instruments.

2. Conduct training at least annually on the policies and procedures developed under this subsection. The training must include, at a minimum:

a. The use of pediatric instruments, as applicable to each licensure type, using clinical simulation as defined in s. 464.003.

b. Drills that simulate emergency situations. Each emergency department must conduct drills at least annually.

(b) Each hospital emergency department must:

1. Designate a pediatric emergency care coordinator. The pediatric emergency care coordinator must be a physician or a physician assistant licensed under chapter 458 or chapter 459, a nurse licensed under chapter 464, or a paramedic licensed under chapter 401. The pediatric emergency care coordinator is responsible for implementation of and ensuring fidelity to the policies and procedures adopted under this subsection.

2. Conduct the National Pediatric Readiness Assessment developed by the National Pediatric Readiness Project, in accordance with timelines established by the National Pediatric Readiness Project.

(6) Each hospital with an emergency department may conduct the National Pediatric Readiness Project's Open Assessment during a year in which the National Pediatric Readiness Assessment is not conducted.

Section 2. Present subsections (4) through (19) of section 395.1055, Florida Statutes, are redesignated as subsections (5) through (20), respectively, a new subsection (4) is added to that section, and paragraph (c) of subsection (1) of that section is amended, to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(c) A comprehensive emergency management plan is prepared and updated annually. Such standards must be included in the rules adopted by the agency after consulting with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records, ~~and~~ responding to family inquiries, and the needs of pediatric and neonatal patients. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of

Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(4) The agency, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, shall adopt rules that establish minimum standards for pediatric patient care in hospital emergency departments, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies.

Section 3. Paragraph (n) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(n)1. Collect the overall assessment score of National Pediatric Readiness Assessments conducted by hospital emergency departments pursuant to s. 395.1012(5), from the Florida Emergency Medical Services for Children State Partnership Program by December 31, 2026, and by each December 31 during a year in which the National Pediatric Readiness Assessment is conducted thereafter.

2. By April 1, 2027, and each April 1 following a year in which the National Pediatric Readiness Assessment is conducted

thereafter, publish the overall assessment score for each hospital emergency department, and provide a comparison to the national average score when it becomes available.

3. Collect and publish no more than one overall assessment score per hospital, per year, of assessments conducted pursuant to s. 395.1012(6), and provide a comparison to the hospital emergency department's most recently published score pursuant to subparagraph 2.

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

2025 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 1602
BILL TITLE:	Health Care Patient Protection
BILL SPONSOR:	Sen. Harrell
EFFECTIVE DATE:	7/1/2025

COMMITTEES OF REFERENCE
1) Senate Health Policy
2) Senate Appropriations Committee on Health and Human Services
3) Senate Fiscal Policy
4)
5)

CURRENT COMMITTEE
Senate Health Policy

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	

IDENTICAL BILLS	
BILL NUMBER:	HB 1119
SPONSOR:	Rep. Oliver

LAST ACTION:	

Is this bill part of an agency package?
Y ___ N _X_

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	3/5/2025
LEAD AGENCY ANALYST:	Jack Plagge
ADDITIONAL ANALYST(S):	Susan Lowery
LEGAL ANALYST:	
FISCAL ANALYST:	

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

SB 1602 requires hospitals with emergency departments to make or amend hospital policy regarding pediatric patient safety presenting to the emergency department. Hospitals are to designate a physician, physician assistant, nurse or paramedic to ensure the requirements of the bill are met are report certain information to the Agency for Health Care Administration (AHCA). Hospitals providing emergency services vary in their capability and capacity to provide specialized services. Based on the hospital's location, size, and medical staff credentials, pediatric services at some hospitals may be very limited. Requiring specific services, staff and equipment to be present at all hospitals may impart a disproportionate cost on some hospitals. The fiscal impact is unable to be determined until the specific requirements are identified in rule.

The effective date of the bill is July 1, 2025. Hospitals are required to report assessment data by December 31, 2026, and the AHCA must post the overall assessment scores by April 1, 2027.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Florida hospitals are licensed under Chapters 395 and 408, Part I, Florida Statutes (F.S.), and Chapters 59A-3 and 59A-35, Florida Administrative Code (F.A.C.). The statutes and rules do not dictate specific specialty services that must be provided. The ultimate responsibility of the operation of a hospital is its governing board. The governing board is responsible for establishing by-laws, protocols, and policies and procedures, including credentialling and granting privileges to medical staff. The policies and procedures, and the credentials of the medical staff determine the types and extent of the services provided at the hospital. The services determine the license classification of the hospital. There are five classes of hospitals, plus subtypes.

<table>
<tr><th>Classification</th><th>Description</th><th>License Count</th></tr>
<tr><td>Class I General Acute Care</td><td>Provides a broad range of services with an average inpatient length of stay of 25 days or less.</td><td>205</td></tr>
<tr><td>Class I Long Term Care</td><td>Provides services requiring an average inpatient stay greater than 25 days.</td><td>27</td></tr>
<tr><td>Class I Rural</td><td>Provides general services and meets the provisions of Chapter 395, Part III, F.S.</td><td>24</td></tr>
<tr><td>Class II Specialty Children's</td><td>Provides general services restricted to a defined age range.</td><td>4</td></tr>
<tr><td>Class II Specialty Women's</td><td>Provides general services restricted to a defined gender.</td><td>0</td></tr>
<tr><td>Class III Specialty Medical</td><td rowspan="4">Provides a range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders.</td><td>2</td></tr>
<tr><td>Class III Specialty Psychiatric</td><td>35</td></tr>
<tr><td>Class III Specialty Rehabilitation</td><td>40</td></tr>
<tr><td>Class II Substance Abuse</td><td>0</td></tr>
<tr><td>Class IV Intensive Residential Treatment Programs for Children and Adolescents (IRTF)</td><td>Has the primary functions of diagnosis and treatment of patients under the age of 18 having psychiatric disorders in order to restore such patients to an optimal level of functioning.</td><td>2</td></tr>
<tr><td>Class V Rural Emergency Hospital</td><td>A rural hospital providing emergency services and no inpatient acute care services</td><td>0</td></tr>
</table>

Hospitals within the same class can vary greatly. Not all general hospitals provide pediatrics on an inpatient basis. Hospitals that do not admit pediatric patients still have an obligation to evaluate, stabilize, and either treat or transfer the patient to an appropriate care setting if presenting to the emergency department for care. Therefore, each hospital providing emergency care should have policies and procedures for the treatment of pediatric patients.

Besides Class II Children's and Class IV IRTF hospitals, AHCA does not track the number of hospitals providing inpatient services to pediatric patients.

Hospitals providing neonatal intensive care unit (NICU) services are limited because of the needed expertise of the practitioners and the extensive supporting services required. There are 70 hospitals providing NICU services: 66 acute care and 4 children's hospitals.

All hospitals are required to create and maintain a comprehensive emergency management plan (CEMP) approved by their county emergency operations center. The CEMP must include actions to be taken in case of any/all foreseeable local, regional, and statewide emergencies. Hospitals must maintain the safety of all patients during an emergency, regardless of age or needs.

2. EFFECT OF THE BILL:

The bill requires each hospital with an emergency department to take additional actions regarding pediatric patient safety when presenting for care at an emergency department. Policies and procedures must address the topics specified in the bill and requires periodic drills to simulate emergency situations. The hospital must have a physician, physician assistant, nurse, or paramedic to serve in the position of pediatric emergency care coordinator.

The coordinator is to ensure the patient safety requirements of this bill are met and conduct the National Pediatric Readiness Assessment. Beginning December 31, 2026, the results of the annual assessment must be sent to the AHCA. The location and route to submit the report is to be determined. The AHCA must post each hospital's overall assessment score beginning April 1, 2027, and annually thereafter. It is not clear in the bill language if the hospitals will submit a final score or the overall results of the survey. The AHCA will need to post the results on AHCA Form 3190-2001OL for each hospital, in accordance with 59A-3.270, Florida Administrative Code.

The AHCA, in consultation with the Florida Emergency Medical Services for Children Partnership Program (Department of Health) is mandated to adopt rules for pediatric patient care in hospital emergency departments, including availability and access to equipment and supplies. Current rules provide for the safety of all patients regardless of age or service area. Mandating specific equipment and supplies for some affected hospitals will impart a cost. The cost, if any, is unable to be determined until the equipment and supplies are identified. Hospitals with lower volume emergency departments, including rural hospitals may see a greater fiscal impact than large metropolitan hospitals treating pediatric patients on a regular basis.

The bill, if enacted, will require updates to regulation sets (ASPEN) and survey process.

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

If yes, explain:	Additional and specific rule authority is provided in Section 2, lines 90-95
Is the change consistent with the agency's core mission?	Y _X__ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	59A-3

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

Proponents and summary of position:	Unknown
Opponents and summary of position:	Unknown

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

If yes, provide a description:	N/A
Date Due:	N/A
Bill Section Number(s):	N/A

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

Board:	N/A
Board Purpose:	N/A
Who Appointments:	N/A

Appointee Term:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

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

Revenues:	None
Expenditures:	None
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

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

Revenues:	None
Expenditures:	None
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

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

Revenues:	None
Expenditures:	To be determined during rule writing if specific equipment and supplies not currently available at some affected hospitals are required by rule.
Other:	N/A

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

If yes, explain impact.	N/A
Bill Section Number:	N/A

TECHNOLOGY IMPACT

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

If yes, describe the anticipated impact to the agency including any fiscal impact.	The Florida Center for Information and Transparency will need to collect data from hospitals and post specific data online. Fiscal impact will be covered under an existing maintenance and operations contract for the posting of this data.

FEDERAL IMPACT

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

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

ADDITIONAL COMMENTS

There is a concern with this bill because statutes and rules do not dictate specific specialty services that must be provided. The ultimate responsibility of the operation of a hospital is its governing board. The governing board is responsible for establishing by-laws, protocols, and policies and procedures, including credentialling and granting privileges to medical staff. The policies and procedures, and the credentials of the medical staff determine the types and extent of the services provided at the hospital. Requiring services to be provided without due consideration of a hospital's capability and capacity may lead to negative outcomes for patients.

Based on the hospital's location, size, and medical staff credentials, pediatric services at some hospitals may be very limited. Requiring specific services, staff and equipment to be present at all hospitals may impart a disproportionate cost on some hospitals, especially those located in rural areas. The fiscal impact is unable to be determined until the specific requirements are identified in rule.

If passed, a rule update will also be needed for 59A-3.270, Florida Administrative Code to update AHCA Form 3190-2001OL.

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	No comment except to note that this bill will require rule making.