Select Committee on Health Innovation

Friday, January 12, 2024
9:00 AM – 1:00 PM
Morris Hall (17 HOB)

Meeting Packet

Paul Renner
Speaker

Kaylee Tuck
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Select Committee on Health Innovation

Start Date and Time:	Friday, January 12, 2024 09:00 am
End Date and Time:	Friday, January 12, 2024 01:00 pm
Location:	Morris Hall (17 HOB)
Duration:	4.00 hrs

Consideration of the following bill(s):

HB 1549 Health Care by Grant

Consideration of the following proposed committee bill(s):

PCB SHI 24-01 -- Public Records and Meetings Exemptions

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Thursday, January 11, 2024.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Thursday, January 11, 2024.

To submit an electronic appearance form, and for information about attending or testifying at a committee meeting, please see the "Visiting the House" tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 01/10/2024 3:55PM by Killings.Anola

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1549 Health Care
SPONSOR(S): Grant
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation		McElroy	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 1549 revises or creates numerous provisions of Florida law relating to the state's health care workforce, health care services, health care practitioner licensure and regulation, health care facility licensure and regulation, the Medicaid program, and health-care-related education programs. Specifically, the bill revises:

- The Dental Student Loan Repayment Program (DSLR Program);
- The Florida Reimbursement Assistance for Medical Education (FRAME) Program;
- The Telehealth Minority Maternity Care Program;
- The Statewide Medicaid Residency Program (SMRP); and
- The Access to Health Care Act.

The bill amends statutes relating to:

- Licensure by endorsement for health care practitioners;
- Mobile response team standards;
- Licensure for foreign-trained physicians;
- Certification of foreign medical schools;
- Medical faculty certificates;
- Autonomous-practice nurse midwives;
- Developmental research laboratory schools; and
- The Linking Industry to Nursing Education (LINE) Fund.

The bill creates:

- The Health Care Screening and Services Grant Program;
- An advanced birth center designation;
- The Training, Education, and Clinicals in Health (TEACH) Funding Program;
- Emergency department diversion requirements for hospitals and Medicaid managed care plans;
- A requirement for the Agency for Health Care Administration (AHCA) to produce an annual report entitled “Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees;”
- Limited licenses for graduate assistant physicians; and
- Temporary certificates for physician assistants (PA) and advanced practice registered nurses (APRN) to practice in areas of critical need.
- Price transparency requirements for hospitals and insurers and medical debt protection for consumers.

The bill provides that Florida will enter into the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact, and the Physical Therapy Licensure Compact. The bill contains numerous appropriations related to the programs and revisions listed above, as well as for provider reimbursement in the Medicaid program.

The bill will have a significant, negative fiscal impact on the Department of Health and AHCA and no impact on local government. *See Fiscal Comments.*

Except as otherwise provided, the bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The term "health care workforce" means a health care professional working in health service settings. Physicians and nurses make up the largest segments of the health care workforce.[1] The United States has a health care professional shortage. As of December 3, 2023, there are 8,544 Primary Care HPSAs, 7,651 Dental HPSAs, and 6,822 Mental Health HPSAs nationwide. To eliminate the shortages, an additional 17,637 primary care practitioners, 13,354 dentists, and 8,504 psychiatrists are needed, respectively.[2]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and the growth of the U.S. population[3] and the expanded access to health care under the federal Affordable Care Act.[4] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.[5] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

Health Care Shortage Designations

The federal Health Resources and Services Administration (HRSA) designates health care shortage areas in the United States. The two main types of health care shortage areas designated by the HRSA are Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA).

Health Care Professional Shortage Areas

A HPSA is a geographic area, population group, or health care facility that has been designated by the HRSA as having a shortage of health professionals. There are three categories of HPSA: primary care, dental health, and mental health.[6]

HPSAs can be designated as geographic areas; areas with a specific group of people such as low-income populations, homeless populations, and migrant farmworker populations; or as a specific facility that serves a population or geographic area with a shortage of providers.[7] As of September 30, 2023,

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[1] Spencer, Ph.D., M.PH., Emma, Division Director, Division of Public Health Statistics and Performance Management, The Department of Health, *Florida's Physician and Nursing Workforce,* presented in Florida Senate Health Policy Committee meeting Nov. 14, 2023, published Nov. 15, 2023, (on file with the Select Committee on Health Innovation).

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas*, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited January 8, 2024).

[3] The U.S. population is expected to increase by 79 million people by 2060, and average of 1.8 million people each year between 2017 and 2060. *See* U.S. *Census Bureau, Demographic Turning Points for the U.S.; Population Projections for 2020 to 2060* (February 2020), available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited January 8, 2024).

[4] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034,* (June 2021), available at https://www.aamc.org/media/54681/download (last visited January 8, 2024).

[5] The nation's 65-and-older population is projected to nearly double in size in coming decades, from 49 million in 2016 to 95 million people in 2060. *See:* U.S. Census Bureau, *U.S. and World Population Clock*, available at https://www.census.gov/popclock/, and U.S. Census Bureau, *U.S. Population Projected to Begin Declining in Second Half of Century* (Nov. 9, 2023), available at https://www.census.gov/newsroom/press-releases/2023/population-projections.html (both sites last visited January 8, 2024).

[6] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, available at https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited January 8, 2024).

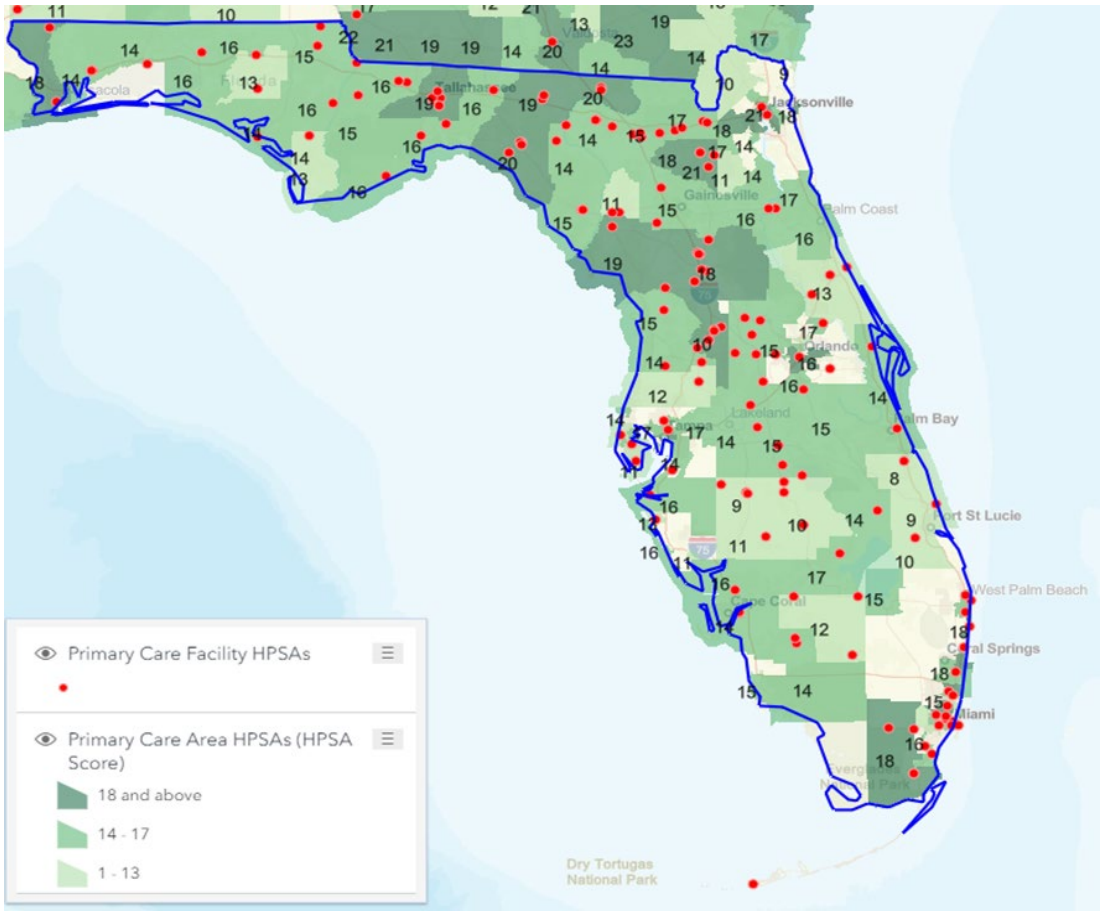
[7] *What is a Shortage Designation?*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited January 8, 2024).

there are 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.[8]

Each HPSA is given a score by the HRSA indicating the severity of the shortage in that area, population, or facility. The scores for primary care and mental health HPSAs can be between 0 and 25 and between 0 and 26 for dental health HPSAs, with a higher score indicating a more severe shortage.[9]

Primary Care HPSAs

Below is a map of primary care HPSAs in Florida with their associated HPSA scores.[10]



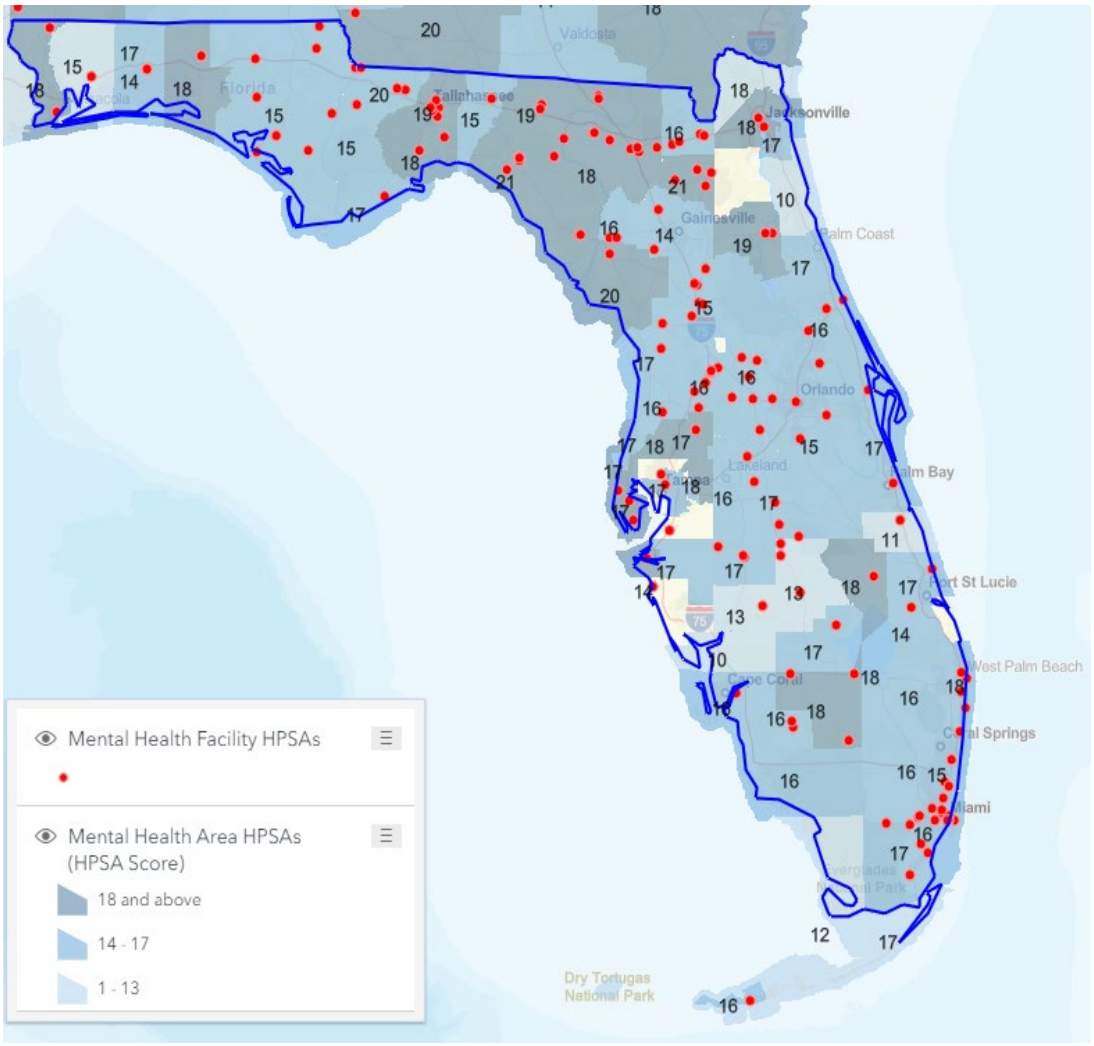
Mental Health HPSAs

Below is a map of mental health HPSAs in Florida with their associated HPSA scores.

[8] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited January 8, 2024). To generate the report, select "Designated HPSA Quarterly Summary."

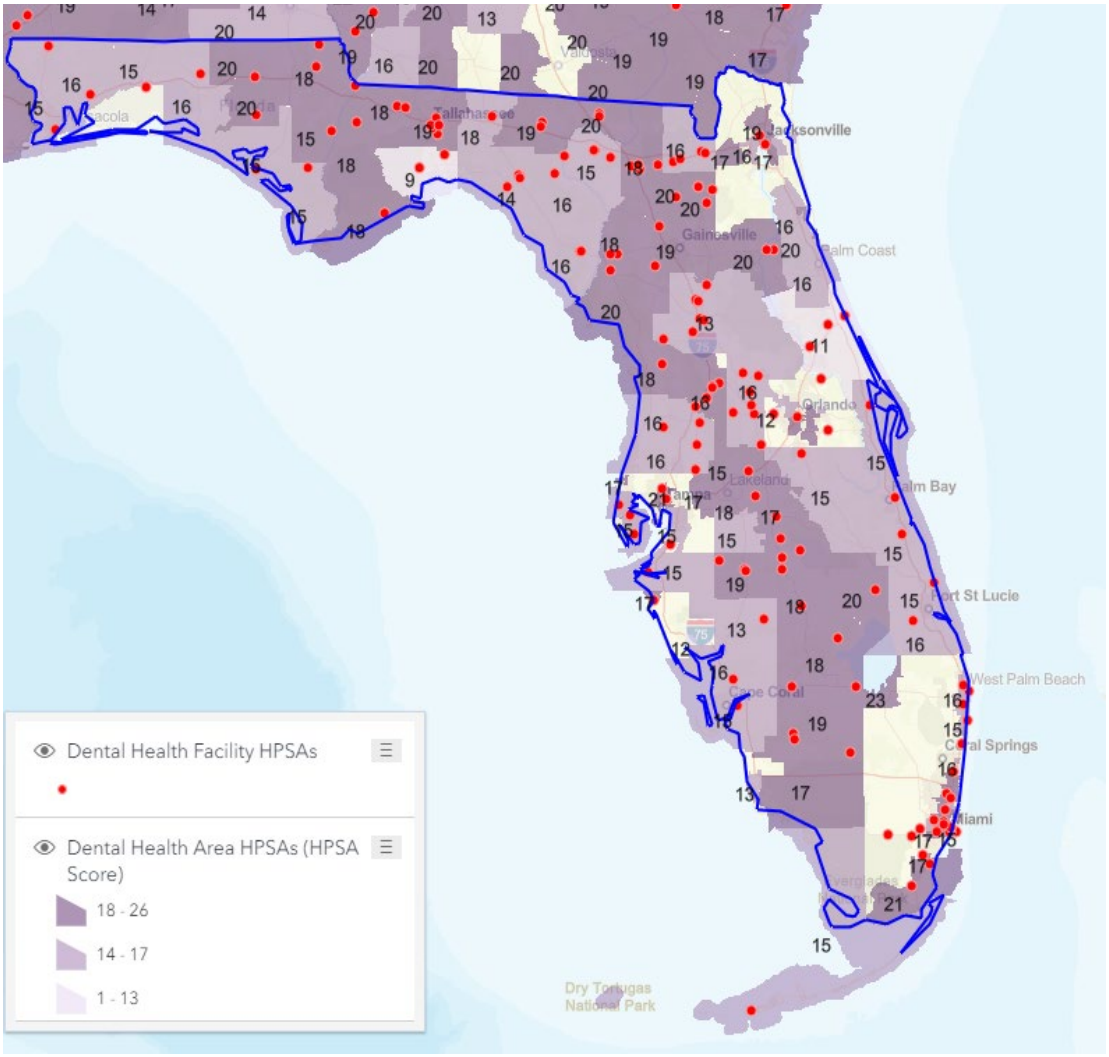
[9] *Scoring Shortage Designations*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring, (last visited January 8, 2024).

[10] The three maps were generated with HRSAs map tool, available at https://data.hrsa.gov/maps/map-tool/, (last visited January 8, 2024).



Dental HPSAs

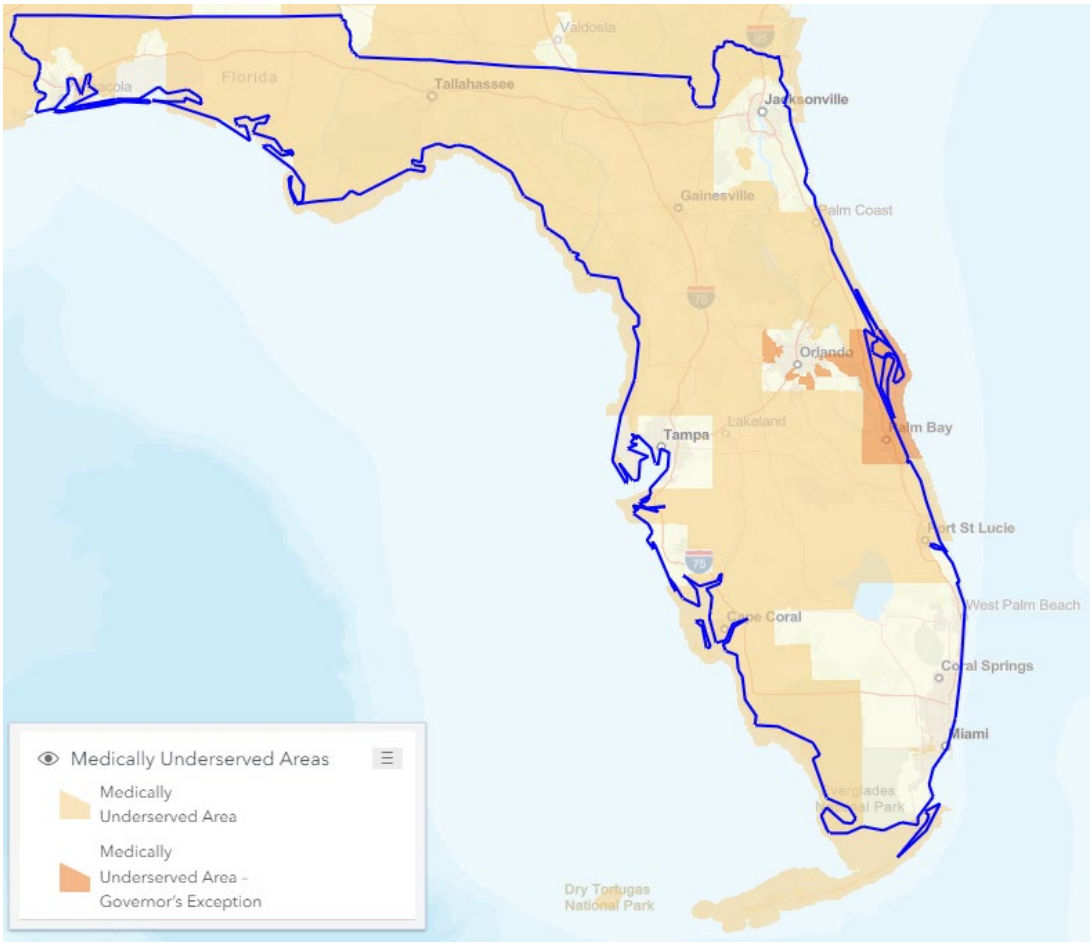
Below is a map of dental health HPSAs in Florida with their associated HPSA scores.


Dental Health Facility HPSAs
Dental Health Area HPSAs (HPSA Score)
18 - 26
14 - 17
1 - 13
Jacksonville
Tallahassee
Gainesville
Palm Coast
Orlando
Lakeland
Palm Bay
Port St Lucie
West Palm Beach
Miami
Dry Tortugas National Park

Medically Underserved Areas

MUAs identify an area with a lack of primary care access. MUAs have a shortage of primary care health services within geographic areas such as:
A whole county
A group of neighboring counties
A group of urban census tracts
A group of county or civil divisions.[11]

Below is a map of the MUAs in Florida.



[11] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, available at https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited January 8, 2024).

The Florida Physician Workforce

In 2020, there were 286.5 physicians actively practicing per 100,000 population in the United States.[12] There were 94,925 total allopathic and osteopathic physicians with an active license in Florida.[13] Of these active physicians, 79,045 or 83.27 percent renewed their medical licenses from July 1, 2021–June 30, 2023, and responded to the statutorily required workforce survey. The DOH used that survey in preparation of the 2023 Physician Workforce Annual Report, which made the following findings regarding the adequacy of Florida's physician work force providing direct patient care to Floridians:

- Of these physicians, there were 56,769 or 72 percent provide direct patient care. Those who renewed during this survey cycle and responded to the survey, were 87.97 percent allopathic physicians and 12.03 percent osteopathic physicians;
- Statewide, 35.82 percent of Florida's 67 counties have a per capita rate of 10 or fewer physicians per 10,000 population;
- The physician work force survey showed that 98.11 percent of physicians work in urban counties while 1.89 percent work in Florida's 31 rural counties. In all of the rural counties, at least 20 percent of physicians are primary care providers;
- Among physicians, 34.17 percent or 19,396 are age 60 and older;
- For physicians under age 40, the percentage of female physicians is 46.21 percent;

The top three specialty groups for physicians providing direct patient care in Florida are:

- Internal medicine (28.11 percent or 15,724);
- Family medicine (14.64 percent or 8,191); and
- Pediatrics (7.89 percent or 4,413);
- Primary care physicians account for 31.63 percent of physicians providing direct patient care;
- 77.45 percent or 40,132 of physicians practice in an office setting and 20.17 percent or 10,451 practice in a hospital;
- 75.28 percent of physicians report they accept patients with Medicare;
- 64.13 percent of physicians report they accept patients with Medicaid;
- A total of 9.56 percent or 5,429 of physicians providing direct patient care plan to retire in the next five years; and
- Just over 2 percent or 1,181 of physicians practice in Florida's rural counties.[14]

IHS Markit Report – Physician Supply and Demand Deficit

In 2021, HIS Markit prepared a report for the Safety Net Hospital Alliance of Florida and the Florida Hospital Association that examined Florida's statewide and regional physician workforce with projections on workforce changes out to 2035.[15] Between 2019 and 2035, the report estimates that while physician supply will increase by six percent overall and by three percent to four percent for primary care, the demand for physician services in Florida will grow by 27 percent.[16] While there is already supply and demand deficits for physician services (estimated by 2019 numbers to be at 1,977 for primary care and 1,650 for non-primary care), the significant growth in the demand for physician services that may outpace the growth in the physician workforce over the next decade is estimated to

[12] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034,* (June 2021), prepared for the AAMC by HIS, Ltd., p. viii, available at https://www.aamc.org/media/54681/download (last visited January 8, 2024). This includes both allopathic and osteopathic physicians.
[13] Department of Health, *2023 Florida Physician Workforce Annual Report*, Nov. 1, 2023, available at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/physician-workforce-development-and-recruitment/2023DOHPhysicianWorkforceAnnualReport-FINAL.pdf (last visited January 8, 2024).
[14] *Id.*
[15] Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035: 2021 Update to Projections of Supply and Demand
[16] *Id.* at V.

create a shortfall of 7,872 in primary care physicians by 2035 and an overall decline in the adequacy for all non-primary care specialties from 95 percent in 2019 to 77 percent in 2035.[17]

The following chart details the estimated supply and demand deficits by physician specialty in 2035:[18]

Specialty	Supply	Demand [a]	Supply-Demand	% Adequacy [b]
Primary Care	**22,900**	**30,773**	**-7,872**	**74%**
Traditional Primary Care	**15,440**	**21,413**	**-5,974**	**72%**
Family Medicine	4,261	8,648	-4,387	49%
General Internal Medicine	6,917	7,797	-881	89%
Pediatric Medicine	3,824	3,870	-46	99%
Geriatric Medicine	437	1,097	-660	40%
Emergency Medicine	2,776	4,295	-1,519	65%
General Surgery	2,228	2,111	117	106%
Obstetrics & Gynecology	2,457	2,954	-497	83%
Non-Primary Care	**33,959**	**44,011**	**-10,052**	**77%**
Allergy & Immunology	276	284	-7	97%
Anesthesiology	3,164	3,818	-654	83%
Cardiology	2,644	3,276	-632	81%
Colorectal Surgery	164	234	-70	70%
Dermatology	1,111	1,044	67	106%
Endocrinology	587	834	-247	70%
Gastroenterology	1,284	1,486	-202	86%
Hematology & Oncology	1,654	2,091	-437	79%
Hospital Medicine	1,993	3,427	-1,434	58%
Infectious Diseases	429	1,167	-737	37%
Neonatology	367	454	-87	81%
Nephrology	758	1,272	-514	60%
Neurological Surgery	458	570	-112	80%
Neurology	1,485	1,314	170	113%
Ophthalmology	1,676	1,731	-55	97%
Orthopedic Surgery	1,751	1,961	-209	89%
Other Specialties	1,063	3,223	-2,160	33%
Otolaryngology	850	771	79	110%
Pathology	1,834	1,605	228	114%
Physical Medicine & Rehabilitation	832	1,313	-481	63%
Plastic Surgery	602	849	-247	71%
Psychiatry	2,037	3,267	-1,230	62%
Pulmonology & Critical Care	1,150	1,798	-648	64%
Radiation Oncology	511	715	-204	71%
Radiology	3,623	2,979	644	122%
Rheumatology	446	560	-114	80%
Thoracic Surgery	329	453	-124	73%
Urology	572	1,030	-459	55%
Vascular Surgery	308	485	-176	64%
Florida Total	**56,859**	**74,784**	**-17,924**	**76%**

Source: IHS Markit

Note: [a] Demand is estimated based on national patterns of healthcare use and delivery applied to the population in Florida and controlling for differences in demographics, disease prevalence, health risk behavior, health insurance, and household income. [b] Adequacy is calculated as supply divided by demand, and indicates whether supply is sufficient to provide a level of care consistent with the national average in 2019.

The Florida Nursing Workforce

During the 2020-2021, license renewal cycle, Florida was home to 441,361 active nursing licenses made up of 69,511 LPN; 326,669 RN; and 45,181 APRN licenses. Licensees held either single-state or multi-state licenses. Multi-state licenses made up 19.6 percent of LPN licenses, 22.2 percent of RN licenses, and 16.9 percent of APRN licenses. There were 366,235 nurses in Florida (83 percent) that responded to the FCN Nursing Workforce Survey.[19]

[17] *Id.* at VI
[18] *Id.* at 10
[19] Florida Center for Nursing, *The State of the Nursing Workforce in Florida, 2023*, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1957&PortalId=0&TabId=151 (last visited January 8, 2024).

The median ages of nurses was 46 for RNs, 48 for LPNs, and 45 for APRNs. The table below provides a comparison of the ages of the LPNs, RNs, and APRNs that make up Florida's nursing workforce to the U.S. nursing workforce and state and U.S. census data.[20]

Age	FL LPNs	FL RNs	FL APRNs	FL NURSES	U.S. NURSES	Florida	United States
29 or younger	12.5%	14.8%	5.2%	11.2%	10.9%	33.7%	38.3%
30 - 39	21.8%	24.3%	31.5%	24.6%	24.2%	12.9%	13.6%
40 - 49	22.2%	20.6%	27.8%	21.5%	21.8%	12.1%	12.4%
50 - 59	22.3%	20.3%	21.1%	21.1%	21.4%	13.3%	12.9%
60 or older	21.1%	20.1%	14.4%	21.6%	21.7%	27.9%	22.8%

The Florida Department of Economic Opportunity develops a *College Projections Report* that includes the *Fastest Growing Occupations between 2020 and 2028*. APRN is the fastest growing profession. The report also includes the Occupations gaining the most new jobs between 2020 and 2028, and RNs are number seven.[21] The number of jobs for LPNs in Florida decreased by 12.19 percent between 2012 and 2021,[22] but LPN jobs have a projected growth of 5,197 jobs (12.6 percent) from 2022-2030 with a total of 31,747 job openings over the eight-year period.[23]

There were 45,181 APRNs licensed on Florida as of the 2020-2021 license renewal. Of those 7,691 (17 percent) are Autonomous APRNs. Thirty for percent of APRNs work in physician's offices while most autonomous APRNs practice in the area of adult and family health (50.1 percent).[24]

Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act

Heath Care Practitioner Licensure and Regulation

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.[25] The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care

[20] *Id.*
[21] The Department of Economic Opportunity, Bureau of Workforce Statistics and Economic Research, 2020- 2028 Employment Projections, updated Feb. 9, 2021, *2020 - 2028 College Projections Report,* available at https://lmsresources.labormarketinfo.com/college_projections/index.html (last visited January 8, 2024).
[22] Florida Center for Nursing, *The State of the Nursing Workforce in Florida, 2023*, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1957&PortalId=0&TabId=151 (last visited January 8, 2024).
[23] Florida Commerce, Bureau of Workforce Statistics and Economic Research, *Occupational Data Search, 29-2061 Licensed Practical or Vocational Nurses*, available at https://floridajobs.org/economic-data/employment-projections/occupational-data-search (last visited January 8, 2024).
[24] Florida Center for Nursing, *Florida Autonomous Practice 2020-2021*, available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1975&PortalId=0&TabId=151 (last visited January 8, 2024).
[25] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.

professions.[26] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.

The self-stated purpose of the MQA is to protect health care consumers.[27] Regulation of health care licensure broadly aids the consumer in differentiating the trained from the untrained and enhancing public health initiatives.[28] Through licensure regulation, the state is able to establish a minimum standard of education and experience necessary for a person to practice a particular profession and ensure a minimum standard of care through enforcement mechanisms which may result in action against a professional's license.[29]

The MQA is statutorily responsible for the following boards and professions established within the division:[30]

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;
- Nursing assistants, as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;
- Midwifery, as provided under ch. 467, F.S.;
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.;
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.;
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.;
- Respiratory therapy, as provided under part V of ch. 468, F.S.;
- Dietetics and nutrition practice, as provided under part X of ch. 468, F.S.;
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.;
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.;
- Electrolysis, as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part III of ch. 483, F.S.;
- Medical physicists, as provided under part IV of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, created under ch. 490, F.S.;
- School psychologists, as provided under ch. 490, F.S.;
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.; and
- Emergency medical technicians and paramedics, as provided under part III of ch. 401, F.S.

[26] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2022-2023*. Available at https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/annual-reports.html (last visited January 8, 2024)
[27] *Id*.
[28] Adams, T.L. (2020). *Health professional regulation in historical context: Canada, the USA and the UK (19th century to present)*. Hum Resour Health 18, 72. https://doi.org/10.1186/s12960-020-00501-y
[29] Section 456.072(2), F.S.; *see also, supra* note 26.
[30] Section 456.001(4), F.S; *see also supra* note 26.

DOH and the practitioner boards have different roles in the regulatory system. Boards establish practice standards by rule, pursuant to statutory authority and directives. DOH receives and investigates complaints about practitioners, and prosecutes cases for disciplinary action against practitioners.[31] The boards determine the course of action and any disciplinary action to take against a practitioner.[32] For professions in which there is no board, DOH determines the action and discipline to take against a practitioner and issues the final orders.[33] DOH is responsible for ensuring that licensees comply with the terms and penalties imposed by the boards.[34]

Pathways to Licensure

Licensure by examination is the most common pathway for individuals seeking initial licensure, particularly among health care professionals educated and trained in Florida. The requirements to qualify for licensure by examination are specified in each profession's respective practice act and vary based on professional standards. However, licensure by examination generally requires, at a minimum, the following from applicants:

- Completion of an approved[35] educational program;
- Completion of an approved[36] licensure or certification examination with a passing score; and
- Submission of an application approved by DOH in conjunction with an application fee.

Licensure by endorsement is the most common alternative to licensure by examination. Licensure by endorsement is an expedited licensure process which allows a health care professional to become licensed in one state based upon holding a substantially equivalent health care professional license in another state.

Currently, only 20 of the health care professions regulated by DOH and the boards authorize licensure by endorsement.[37]

[31] Section 456.072(2), F.S.
[32] Section 456.072(2), F.S.
[33] *Id*. Professions which do not have a board include naturopathy, nursing assistants, midwifery, respiratory therapy, dietetics and nutrition, electrolysis, medical physicists, and school psychologists.
[34] Department of Health, *Prosecution Services.* Available at http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited January 8, 2024).
[35] The requirements for "approval" of an educational program or examination vary by profession; some practice acts outline specific qualifications such as accreditation with a national board, while others grant the relevant regulatory board discretion in determining such requirements.
[36] *Id*.
[37] Email from Jennifer Wenhold, Division of Medical Quality Assurance Director, Florida Department of Health, RE: Endorsement Info, July 13, 2023. On file with the Health and Human Services Committee.

Professions With Licensure by Endorsement	Professions Without Licensure by Endorsement
Acupuncturist	Anesthesiologist Assistant
Allopathic Physician (MD)	Athletic Trainer
Audiologist	Chiropractor
Certified Nursing Assistant (CNA)	Clinical Laboratory Personnel
Mental Health Professions	Dental Hygienist
Dietitian	Dentist
Electrologist	EMT/Paramedic
Licensed Practical Nurse	Genetic Counselor
Massage Therapist	Hearing Aid Specialist
Midwifery	Medical Physicist
Nursing Home Administrator	Optometrist
Occupational Therapist	Optician
Pharmacist	Orthotist and Prosthetist
Physical Therapist	Osteopathic Physician (DO)
Physical Therapist Assistant	Physician Assistant
Psychologist	Podiatrist
Radiation Technician	Registered Pharmacy Technician
Registered Nurse (RN/APRN)	
Respiratory Therapist	
Speech-Language Pathologist	

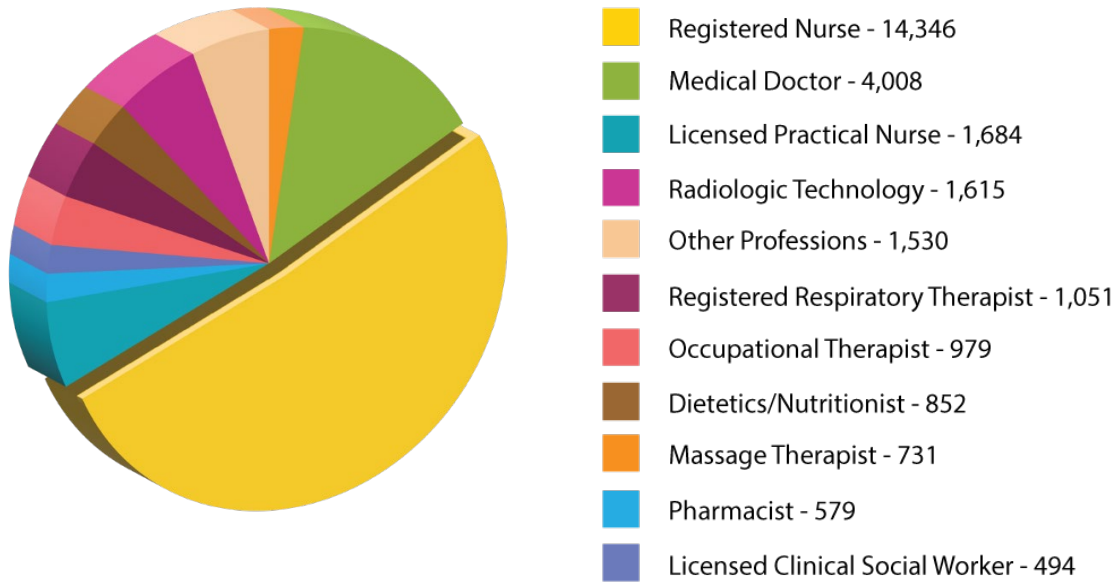
Even amongst the professions which allow licensure by endorsement there are no standard requirements. Rather, requirements to obtain licensure by endorsement vary greatly by profession. For example, some professions require that the applicant submit to a background screening,[38] have a certain amount of prior practice experience,[39] or pass an exam on Florida rules and laws relevant to the profession[40].

[38] Allopathic Physicians, Certified Nursing Assistants, Licensed Practice Nurses, Registered Nurses, and Massage Therapists.
[39] Allopathic Physicians, Mental Health Professionals, Licensed Practical Nurses, Registered Nurses, Nursing Home Administrators, Pharmacists, and Psychologists.
[40] Mental Health Professions, Licensed Practical Nurses, Registered Nurses, Nursing Home Administrators, Pharmacists, Psychologists, and Radiology Technicians.

From FY 18-19 to FY 22-23 DOH approved 136,533 licenses by endorsement.[41] During that time DOH reduced the average business days to issue such licenses from 2.5 days to 1.4 days.[42]

Fiscal Year	Total Licenses by Endorsement	Avg Business Days to Issue License
FY18-19	21,492	2.495
FY19-20	21,841	2.091
FY20-21	29,258	1.450
FY21-22	36,073	1.380
FY22-23	27,869	1.379
Overall	**136,533**	**1.672**

In FY 2022-23 DOH approved 27,869 applications for licensure by endorsement for the various professions listed below.[43]



Licensure Fees

Health care practitioner regulation is typically funded through fees paid during the licensure process. Current law expressly states that all costs of regulating health care professions and practitioners are to be borne solely by licensees and licensure applicants.[44] Such fees should be reasonable and not serve as a barrier to licensure.

Section 456.025(3), F.S., directs the regulatory boards, or DOH if there is no board, to establish by rule license fee amounts for the profession it regulates and ensure that such fees are adequate to cover all anticipated expenses relating to the board and maintain a reasonable cash balance. Fees are to be based upon long-range estimates prepared by the Department of the Revenue required to implement laws relating to the regulation of professions by the department and the board.

[41] Correspondence from Department of Health to Health and Human Services Committee staff dated 8/11/23 on file with the Health and Human Services Staff.
[42] *Id.*
[43] Florida Department of Health presentation to the Health Care Regulation Subcommittee on November 16, 2023.
[44] Section 456.025, F.S.

Current law specifies that licensure renewal fees established by rule must be:[45]

- Based on revenue projections prepared using generally accepted accounting procedures;
- Adequate to cover all expenses relating to that board identified in the department's long-range policy plan;
- Reasonable, fair, and not serve as a barrier to licensure;
- Based on potential earnings from working under the scope of the license; and
- Similar to fees imposed on similar licensure types.

The fees may not be more than 10 percent greater than the actual cost to regulate that profession for the previous biennium.

Effect of bill - Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act

The bill repeals existing licensure by endorsement statutes and establishes a single standardized process for licensure by endorsement for all health care professions regulated by DOH, not just the 20 that currently allow it. The bill requires applicants seeking licensure by endorsement to submit an application and meet the following requirements:

- Hold an active, unencumbered license with a similar scope of practice[46] in a US jurisdiction;
- Have obtained a passing score on a national licensure examination or national certification, if the profession requires such;
- Have actively practiced the profession for two of the last four years;
- Attest that they are not currently subject to a disciplinary hearing for any offense related to the profession for which they are applying for licensure in any US jurisdiction, nor has had disciplinary action taken against their license in the five years preceding application;
- Meet the financial responsibility requirements of s. 456.048 or the applicable practice act, if required for the profession for which the applicant is seeking licensure; and
- Submit a set of fingerprints for a background screening pursuant to s. 456.0135, if required for the profession for which he or she is applying.

Under the bill, a person is ineligible for licensure under this section if they:

- Have a complaint, allegation, or investigation pending before a licensing entity in another state, the District of Columbia, or a possession or territory of the United States;
- Have been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Have had a health care provider license revoked or suspended from another of the United States, the District of Columbia, or a United States territory or has voluntarily surrendered any such license;
- Have been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his or her name removed from the data bank; or
- Have previously failed the Florida examination required to receive a license to practice the profession for which the applicant is seeking a license.

The bill gives the regulatory boards, or DOH if there is no board, the authority to revoke a license issued under this section upon a finding that the individual provided false or misleading material information in an application for licensure.

The bill requires that the regulatory board, or DOH if there is no board, issue a license under this section within 7 days after receipt of all required documentation for the application.

[45] Section 456.025(1), FS. Such fees are subject to challenge pursuant to Ch. 120, F.S.
[46] The bill defines "scope of practice" to mean the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license.

The bill authorizes the regulatory board, or DOH if there is no board, to require the applicant complete a jurisprudence exam specific to Florida state laws and rules as a condition of licensure if such an exam is required by ch. 456, F.S., or the relevant practice act.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill requires DOH submit an annual report to the Governor, the President of the Senate, and the Speaker of the House, providing the following information:

- The number of applications for licensure received under this section, distinguished by profession.
- The number of licenses issued under this section.
- The number of applications submitted under this section which were denied and the reason for such denials.
- The number of complaints, investigations, or other disciplinary actions taken against health care practitioners who are licensed under this section.
  The bill directs the regulatory boards and DOH to adopt rules necessary to implement the contents of this section within six months of this section's effective date.

Interstate Compacts

An interstate compact is a legal contractual agreement between two or more states to address common problems or issues, create an independent, multistate governmental authority, or establish uniform guidelines, standards or procedures for the compact's member states.[47] Article 1, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other, without the consent of Congress. However, the case law has provided that not all interstate agreements are subject to congressional approval, but only those that may encroach on the federal government's power.[48]

To join a compact, states must enact compact legislation and meet the requirements of the compact. Florida is a party to multiple interstate health care compacts, including the Nurse Licensure Compact,[49] Professional Counselors Licensure Compact,[50] and the Psychology Interjurisdictional Compact.[51]

Telehealth

A Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[52] or a registered out-of-state-health care provider is authorized to provide health care services to Florida patients via telehealth.[53] Current law sets the standard of care for telehealth providers at the same level as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

Under current law, in-state and out-of-state licensed or registered health care practitioners may use telehealth to provide health care services to patients physically located in Florida.[54] The law does not allow health care practitioners to use telehealth to provide services to out-of-state patients.

[47] National Center for Interstate Compacts, *What Are Interstate Compacts?,* https://compacts.csg.org/compacts/ (last visited November 30, 2024).
[48] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[49] Section 464.0095, F.S.
[50] Section 491.017, F.S.
[51] Section 490.0075, F.S.
[52] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[53] Section 456.47(4), F.S.
[54] Section 456.47(1) and (4), F.S.

Sovereign Immunity

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through an enactment of general law. [55]

Current law partially waives sovereign immunity, allowing individuals to sue state government and its subdivisions.[56] Individuals may sue the government under circumstances where a private person "would be liable to the claimant, in accordance with the general laws of [the] state . . . . " Section 768.28(5), F.S., imposes a $200,000 limit on the government's liability to a single person, and a $300,000 total limit on liability for claims arising out of a single incident.

Impaired Practitioner Program

The impaired practitioner treatment program was created to provide resources to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or both, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety.[57] For a profession that does not have a program established within its individual practice act, the Department of Health (DOH) is required to designate an approved program by rule.[58] By rule, DOH designates the approved program by contract with a consultant to initiate intervention, recommend evaluation, refer impaired practitioners to treatment providers, and monitor the progress of impaired practitioners. The impaired practitioner program may not provide medical services.[59]

Audiology and Speech-Language Pathology Interstate Compact

Speech-Language Pathology and Audiology Licensure in Florida

The Board of Speech-Language Pathology and Audiology (SLPA Board) within the Department of Health (DOH) oversees the licensure and regulation of speech-language pathologist and audiologist in Florida.[60] DOH must issue a license to any applicant whom the Board certifies is qualified to practice speech-language pathology or audiology and who has paid the initial licensure fee.[61]

To receive license to practice speech-language pathology, an individual must meet the following requirements:[62]

- Received a master's or doctoral degree with a major emphasis in speech-language pathology from an institution accredited by:
  - An agency recognized by the Council for Higher Education Accreditation;
  - The U.S. Department of Education or its successor;
  - An institution that is a member in good standing with the Association of Universities and Colleges of Canada; or
  - From an institution outside of the U.S. or Canada that has been determined to be equivalent to an accredited U.S. institution;

[55] Fla. Const. art. X, s. 13.
[56] Section 768.28, F.S.
[57] Section 456.076, F.S. The provisions of s. 456.076, also apply to veterinarians under s. 474.221, F.S. and radiological personnel under s. 486.315, F.S.
[58] Section 456.076(1), F.S.
[59] Rule 64B31-10.001(1)(a), F.A.C.
[60] Section 468.1135, F.S.
[61] Id.
[62] Section 468.1185. F.S., and Florida Board of Speech-Language Pathology & Audiology, *Speech-Language Pathologist*, at https://floridasspeechaudiology.gov/licensing/speech-language-pathologist/, (last visited January 8, 2024).

- Completed 300 clock hours of supervised clinical experience with at least 200 hours in the area of speech-language pathology;
- Completed nine months of professional employment experience, or its part-time equivalent; and
- Passage of the national examination (Praxis Exam) within three years prior to the date of application.

To receive license to practice audiology, an individual must meet the following requirements:[63]

- Received a doctoral degree with a major emphasis in audiology from an institution accredited by;
  - An agency recognized by the Council for Higher Education Accreditation or its successor;
  - The U.S. Department of Education;
  - An institution that is a member in good standing with the Association of Universities and Colleges of Canada; or
  - From an institution outside of the U.S. or Canada that has been determined to be equivalent to an accredited U.S. institution;
- Completed 300 clock hours of supervised clinical experience with at least 200 hours in the area of audiology;
- Completed eleven months of clinical experience or one-year clinical work experience within the doctoral program; and
- Passage of the Praxis exam within the three years prior to the date of application.

Audiology and Speech-Language Pathology Interstate Compact

The Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC or compact) is mutual recognition licensure compact that allows an audiologist or speech-language pathologists who holds a license in their home state to apply for a "compact privilege" to practice in another state.[64] Compact privilege also authorizes an audiologist or speech-language pathologist licensed by a home state to practice telehealth in member states. To exercise compact privilege under the ASLP-IC, the audiologist or speech-language pathologist must:

- Hold an active license in the home state (for purposes of compact privilege, the licensee may only hold one home state license at a time);
- Be eligible for compact privilege in any member state;
- Have no encumbrance on any state license;
- Have no adverse actions taken against the license or compact privilege within the previous two (2) years;
- Pay any applicable fees, including any state fee, for the compact privilege;
- Function within the laws and regulations of the remote state when providing services in such state; and
- Report to the ASLP-IC Commission any adverse action taken against his or her license by any non-member state within 30 days from the date the adverse action is taken.

If the home state license is encumbered, the licensee shall lose the compact privilege in all remote states until the home state is no longer encumber and two (2) years have passed since the adverse action.

Under the compact, the privilege to practice is renewable upon the renewal of the home state license.

[63] Section 468.1185. F.S., and Florida Board of Speech-Language Pathology & Audiology, *Audiologist*, at https://floridasspeechaudiology.gov/licensing/audiologist/, (last visited January 8, 2024).
[64] The ASLP-IC defines "compact privilege" as the authorization granted by a remote state to allow a licensee from another member state to practice as an audiologist or speech-language pathologist in the remote state under its laws and rules. *Id.*

State Participation in the Audiology and Speech-Language Pathology Interstate Compact

To participate in the ASLP-IC states must implement procedures for considering the criminal history records (background screening) of applicants for the initial privilege to practice.[65] These procedures must include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information.

Each member state must require an applicant to obtain or retain a license in the home state and meet the home state's qualifications for licensure or renewal of licensure, as well as, all other applicable state laws. Applicants for licensure to meet the following requirements:

For licensure as an audiologist the applicant must:

- Have graduated with a master's or doctoral degree (on or before December 31, 2007) or with a doctoral degree (on or after January 1, 2008) in audiology, or an equivalent degree regardless of degree name, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the U.S Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or
    - Have graduated from an audiology program that is housed in an institution of higher education outside of the United States and:
        - For which the program and institution have been approved by the authorized accrediting body in the applicable country; and
        - The degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.
- Have completed supervised clinical practicum experience from an accredited educational institution or its cooperating programs as required by the board;
- Passed a national examination approved by the compact's commission;
- Hold an active, unencumbered license;
- Have not be convicted or found guilty, or have entered into an agreed disposition, of a felony related to the practice of audiology, under applicable state or federal criminal law; and
- Have a valid United States Social Security or National Practitioner Identification number.

For licensure as a speech-language pathologist the applicant must:

- Have graduated with a master's degree from a speech-language pathology program that is accredited by an organization recognized by the U.S. Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or
    - Have graduated from a speech-language pathology program that is housed in an institution of higher education outside of the United States and;
        - For which the program and institution have been approved by the authorized accrediting body in the applicable country; and
        - The degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.
- Have completed a supervised clinical practicum experience from an educational institution or its cooperating programs as required by the ASLP-IC commission;
- Have completed supervised postgraduate professional experience as required by the ASLP-IC commission;

[65] Under the compact, the initial privilege to practice is granted when a licensed audiologist or speech-language pathologist completes the necessary steps to gain eligibility to apply for the privileges to practice under the compact. These steps are completed by the licensee's home state, and include verifying the applicant's education, examination record, and criminal history record. ASLP-IC, Frequently Asked Questions, at https://aslpcompact.com/wp-content/uploads/2023/10/ASLP-IC-Frequently-Asked-Questions-10-7-23.pdf, (last visited January 8, 2024).

- Passed a national examination approved by the compact's commission;
- Hold an active, unencumbered license;
- Have not be convicted or found guilty, or have entered into an agreed disposition, of a felony related to the practice of speech-language pathology, under applicable state or federal criminal law;
- Have a valid United States Social Security or National Practitioner Identification number.

Audiology and Speech-Language Pathology Compact Commission

The compact establishes the Audiology and Speech-Language Compact Commission (Commission) which is responsible for establishing rules and enforcing the compact. Commission membership consist of compact member states. The licensing board of each member state must delegate two (2) members, one audiologist and one speech-language pathologist, to serve on the Commission. Delegates must be current members of the state licensing board. Each delegate is granted one vote in regard to the promulgation of rules and creation of bylaws and must have the opportunity to participate in the business and affairs of the Commission. The compact requires the Commission to establish and elect an executive committee to act on behalf of, and within the powers granted to them by the Commission.

All Commission and executive committee meetings must be open to the public and public notice of the meeting must be provided. However, the Commission or the executive committee or other committees of the Commission may convene in a closed, non-public meeting if confidential or privileged information must be discussed. Nothing in the compact shall be construed to be a waiver of sovereign immunity.

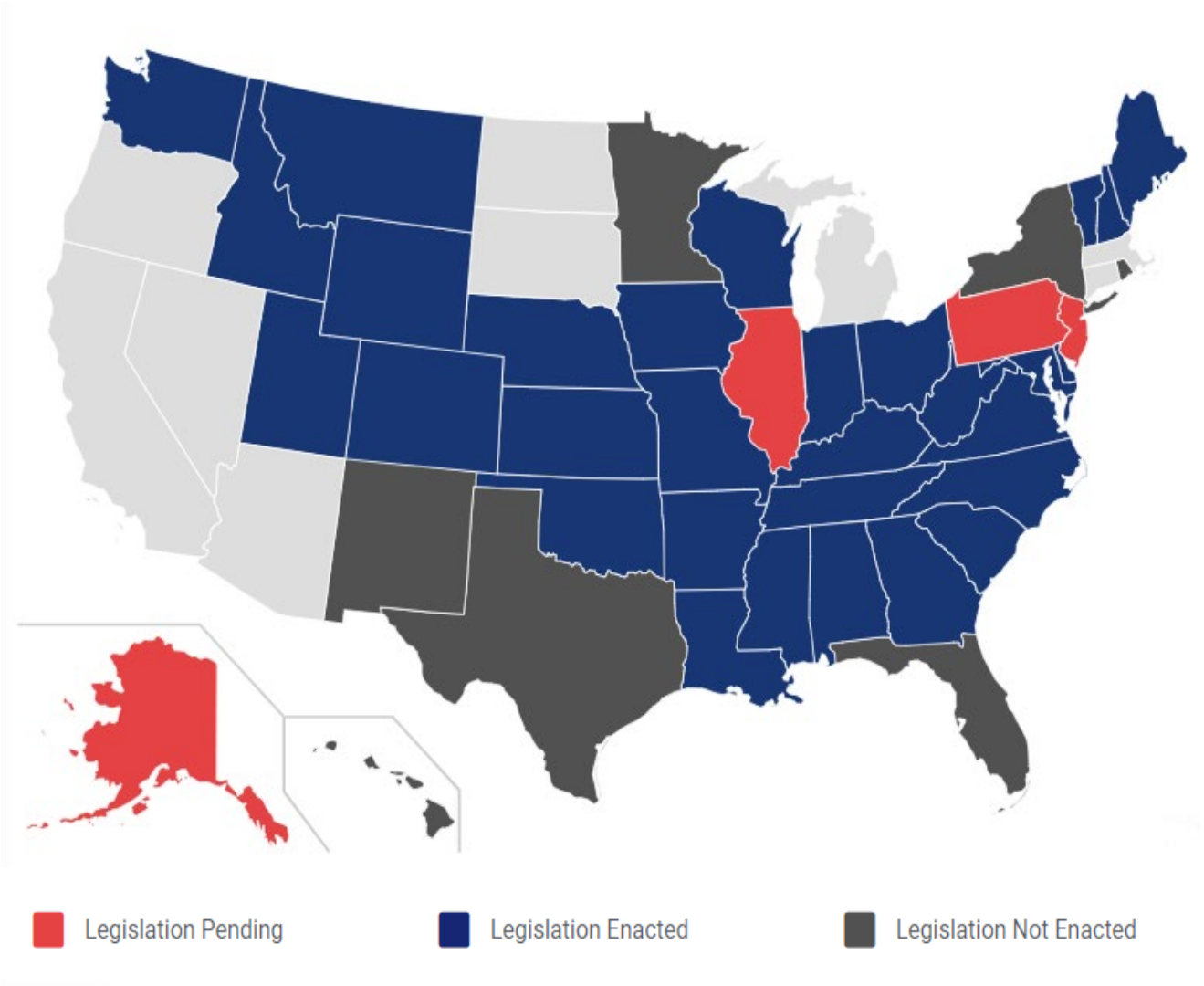
Shared Data System

The compact requires the Commission to develop and maintain a coordinated database and reporting system containing certain information on all licensed individuals in member states. Member states must submit licensure information to the data system for all audiologists and speech-language pathologists to whom the compact applies, including, identifying information, licensure data, and any adverse actions taken against the provider's license. The shared data system will allow for the expedited sharing of adverse action against the license of compact audiologists and speech-language pathologists.[66] A member state contributing information to the data system may designate information that may not be shared with the public without the express permission of that member state.

Enactment of the Compact

The compact became effective on the date of enactment in the tenth compact state which occurred on April 1, 2021.[67] ASLP-IP currently has 29-member states. The compact is in the process of establishing the commission and operationalizing the compact. The compact anticipate it will begin accepting applications for compact privilege in early 2024.

[66] ASLP-IC, *Section-by-Section Overview*, at https://aslpcompact.com/wp-content/uploads/2019/09/90792-ASLP-IC-Section-Flyer_Final.pdf, (last visited January 8, 2024).
[67] American Speech-Language-Hearing Association, *Nebraska Becomes the Critical 10th State to Adopt the Interstate Compact,* at https://www.asha.org/news/2021/nebraska-becomes-10th-state-to-adopt-compact/, (last visited January 8, 2024).



Effect of the bill - Audiology and Speech-Language Pathology Interstate Compact

The bill requires Florida to join the Audiology and Speech-Language Pathology Interstate Compact. The bill authorizes eligible licensed Florida audiologists and speech-language pathologists to obtain a compact privilege to provide services to out-of-state patients in person or through telehealth in compact member states. It also allows out-of-state licensed audiologists and speech-language pathologists in member states with a Florida compact privilege to provide services to Floridians via telehealth and in-person.

The bill amends current law to allow compact implementation. The bill requires the SLPA Board to implement procedures for back ground screening, including the submission of fingerprints or other biometric-based information, of applicants applying for licensure for the purpose of obtaining the applicant's criminal history information. The bill also requires the SLPA Board to submit certain specified information on all licensed audiologists and speech-language pathologists practicing under the compact to a shared data system, including, identifying information, licensure data, and any adverse actions taken against the audiologist or speech-language pathologist's license. It requires audiologists and speech-language pathologists to withdraw from all practice under the compact if the audiologist or speech-language pathologist is in an impaired practitioner program. The bill also exempts out-of-state licensed audiologists and speech-language pathologists who practice under the compact from licensure requirements in this state. Further, the bill authorizes the SLPA Board to take adverse action against a licensed audiologist or speech-language pathologist's privilege to practice under the compact and impose disciplinary actions for violation of prohibited acts.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill preserves the regulatory authority of the state's current system of state licensure and does not require changes to Florida's licensure and license renewal requirements.

Interstate Medical Licensure Compact

Licensure of Florida Physicians

The regulation of the practices of medicine and osteopathic medicine in Florida fall under chapters 458 and 459, F.S., respectively. The practice acts for both professions establish the regulatory boards, a variety of licenses, the application process with eligibility requirements, and financial responsibilities for the practicing physicians. The boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[68] Such standards may include education and training, medication including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[69]

Licensure by Examination

The general requirements for licensure under both practice acts are very similar with the obvious differences found in the educational backgrounds of the applicants. Where the practice acts share the most similarities are the qualifications for licensure. Both the Board of Medicine and the Board of Osteopathic Medicine require their respective applicants to meet these minimum qualifications:[70]

- Complete an application form as designated by the appropriate regulatory board.
- Be at least 21 years of age.
- Be of good moral character.
- Have completed at least two years (medical) or three years (osteopathic) of pre-professional post-secondary education.
- Have not previously committed any act that would constitute a violation of this chapter or lead to regulatory discipline.
- Have not had an application for a license to practice medicine or osteopathic medicine denied or a license revoked, suspended or otherwise acted upon in another jurisdiction by another licensing authority.
- Must submit a set of fingerprints to DOH for a criminal background check.
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the applicant's respective professional association.
- Demonstrate that she or he has successfully completed an internship or residency (osteopathic) or supervised clinical training (medical) of not less than 12 months in an accredited program (osteopathic) or hospital (medical) approved for this purpose by the applicant's respective professional association.
- Demonstrate that he or she has obtained a passing score, as established by the applicant's appropriate regulatory board, on all parts of the designated professional examination conducted by the regulatory board's approved medical examiners no more than five years before making application to this state; or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than five years after the applicant obtained a passing score on the required examination.

[68] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[69] *Id.*
[70] Sections 458.311 and 459.0055, F.S.

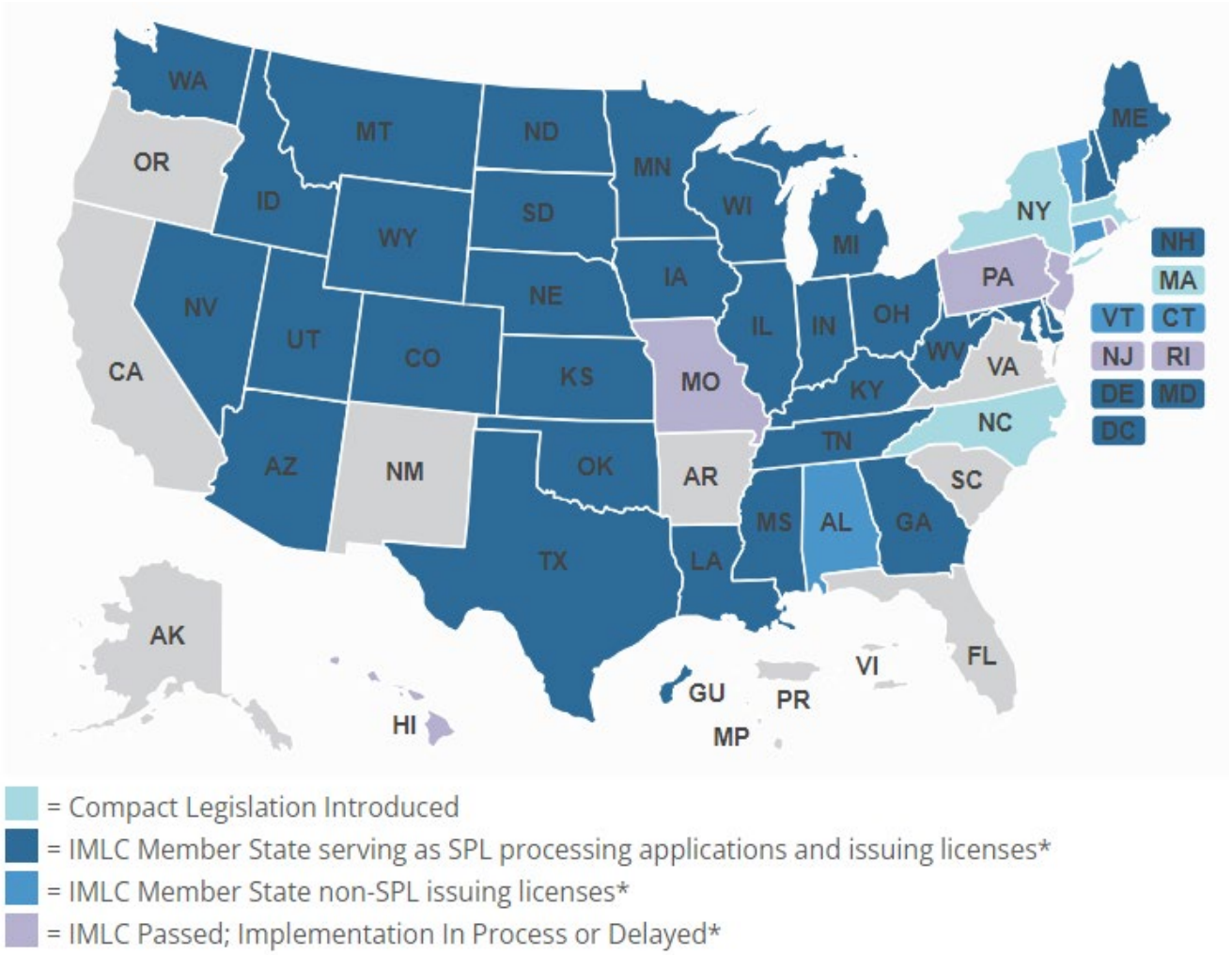
The current licensure application fee for a medical doctor is $350 and is non-refundable.[71] Applications must be completed within one year. If a license is approved, the initial license fee is $355.

For osteopathic physicians, the current application fee is non-refundable $200, and if approved, the initial licensure fee is $305.[72] The same application validity provision of one year applies and the processing time of two to six months is the range of time that applicants should anticipate for a decision.[73]

The Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (Medical Licensure Compact or compact)creates an expedited path to licensure by setting qualifications for licensure and outlining a process for physicians to apply and receive licenses in states where they are not currently licensed.[74] Thirty-seven states, the District of Columbia, and the Territory of Guam have adopted the compact.[75]

[71] Florida Board of Medicine, *Medical Doctor - Fees,* available at https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited January 8, 2024).
[72] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees,* available at https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/#tab-fees, (last visited January 8, 2024).
[73] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process,* available at https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/#tab-process, (last visited January 8, 2024).
[74] Id.
[75] Interstate Medical Licensure Compact, *The IMLC*, available at https://www.imlcc.org/participating-states/, (last visited January 8, 2024).

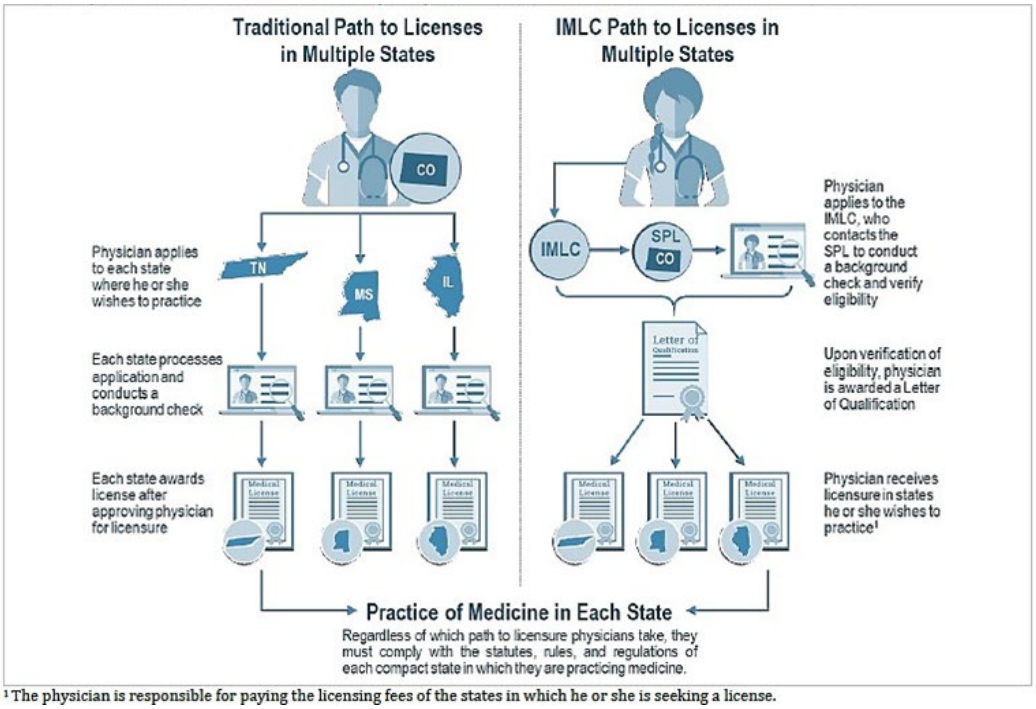


Physician Licensure under the Compact

Typically, if a physician wishes to be licensed in more than one state, the physician must separately apply to each state. The physician must submit documentation to verify qualification for licensure prior to the state issuing a license. However, under the compact the physician must designate a member state as his or her home state or state of principal licensure (SPL)[76] and file an application for an expediated license[77] with the member board (state licensing agency) of the SPL. The SPL verifies the physician's qualifications for licensure by collecting and reviewing all required documents related to training and education and performing a background screening.[78] If the physician meets the required compact qualifications, the SPL will issue a Letter of Qualification. The physician may then submit the Letter of Qualification, along with applicable fees, to the states in which the physicians wishes to be licensed.[79] The Letter of Qualification is valid for 365 days.[80]

[76] The compact defines the "state of principal license" as a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.
[77] The compact defines "expediated license" as a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.
[78] Interstate Medical Licensure Compact, *About*, available at https://www.imlcc.org/a-faster-pathway-to-physician-licensure/, (last visited January 8, 2024).
[79] Id.
[80] Rule 5.6 of the IMLCC Rules, available at https://www.imlcc.org/wp-content/uploads/2023/11/IMLCC-Rule-Chapter-5-Expedited-Licensure-Amended-November-14-2023-FINAL.pdf, (last visited January 8, 2024).

Licensure under the Compact[81]



[1] The physician is responsible for paying the licensing fees of the states in which he or she is seeking a license.

To be eligible to receive a license under the compact, a physician must hold a full unrestricted medical license in a compact member state that can be declared the physician's SPL. To designate a state as a SPL, the physician must ensure that at least one of the following apply:

- The physician's primary residence is in the SPL;
- At least 25% of the physician's practice of medicine occurs in the SPL;
- The physician is employed to practice medicine by a person, business or organization located in the SPL; or
- The physician uses the SPL as his or her state of residence for U.S. Federal Income Tax purposes.

The physician must also meet the following requirements to be licensed under the compact:

- Have graduated from a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;
- Have passed each component of the United States Medical Licensing Exam (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMPLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;
- Have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;
- Hold a specialty certification or time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Board of Osteopathic

[81] Office of Program Policy Analysis and Gov't Accountability, Florida Legislature, *Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts*, Report No. 19-07, (Oct. 1, 2019) available at https://oppaga.fl.gov/Documents/Reports/19-07.pdf, (last visited January 8, 2024).

Specialties; however, the times unlimited specialty certificate does not have to be maintained once the physician is initially determined through the expedited Compact process;
- Possess a full and unrestricted license to engage in the practice of medicine issued by a member board;[82]
- Have never been convicted received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
- Have never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license;
- Have never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and
- Not be under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

A physician who does not meet the above-listed criteria may still obtain a non-compact license from a member state if the physician meets the requirements to practice in that state.

Upon completion of eligibility verification process by the compact member state, applicants suitable for an expedited license are directed to complete the registration process with the Interstate Medical Licensure Compact Commission (Commission), including the payment of any fees. After completing the registration process and paying the appropriate fees, the member board will issue an expedited license to the physician. The license authorizes the physician to practice medicine in the issuing state consistent with the laws and regulations of the issuing member board and member state.

An expedited license is valid for a period consistent with the member state licensure period and in the same manner as required for other physicians holding a full and unrestricted license. The expedited license must be terminated if a physician fails to maintain a license in the SPL for a non-disciplinary reason, without re-designation of a new SPL.

The compact authorizes the Commission to adopt rules regarding the application process, including the payment of any applicable fees, and the issuance of an expedited license. The compact also gives states issuing an expediated license authorizing physicians to practice in the compact the discretion to impose fees for licensure or renewal through the compact. However, the compact does not authorize DOH to collect a fee, but rather states that fees of this kind are allowable under the compact.

License Renewal and Continued Compact Participation

The compact requires the member board to notify a physician at least 90 days prior to the expiration of a license issued through the compact.[83] To renew a compact license the physician must:

- Maintain a full and unrestricted license in a SPL;
- Not have been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
- Not have had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action relating to non-payment of fees related to a license; and
- Not have had a controlled substance license or permit suspended or revoked by a state or the United State Drug Enforcement Administration.

[82] The compact defines “member board” as the state agency in the member state that acts in the sovereign interest for the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government. Under the compact, DOH would be the member board in Florida.
[83] Rule 5.8 of the IMLCC Rules, available at https://www.imlcc.org/wp-content/uploads/2023/11/IMLCC-Rule-Chapter-5-Expedited-Licensure-Amended-November-14-2023-FINAL.pdf, (last visited January 8, 2024).

Physicians must also comply with all continuing education and professional development requirements for renewal of a license issued by a member state.

The Commission collects any renewal fees charged for the renewal of a license and distribute the fees to the appropriate member board. Upon payment of fees, a physician's license may be renewed. Any information collected during the renewal process shall also be shared with all member boards.

Interstate Medical Licensure Compact Commission

The compact establishes the Interstate Medical Licensure Compact Commission to oversee and maintain the administration of the compact. The Commission has all the duties, powers, and responsibilities set forth in the compact, plus any other powers conferred upon it by the member states through the compact. Each member state has two voting representatives appointed by each member state to serve as Commissioners. For states with separate regulatory boards for allopathic and osteopathic regulatory boards, such as Florida, the member appoints one representative from each member board. A Commissioner must be:

- An allopathic or osteopathic physician appointed to a member board.
- An executive director, executive secretary, or similar executive or a member board, or
- A member of the public appointed to a member board.

The compact requires the Commission to establish an executive committee, which shall have the power to act on behalf of the Commission. All Commission and executive committee meetings must be open to the public and public notice must be provided. However, a meeting may be closed to the public, in full or in portion, when it is determined by a two-thirds vote of the Commissioners present, that an issue or matter to be discussed is confidential or privileged as designated in the compact. The Commission must make its information and official records, to the extent, not otherwise designated in the compact or by its rules, available to the public for inspection.

Coordinated Information System

The compact requires the Commission to establish a database of all physicians licensed, or who have applied for licensure under the compact. Member boards are required to report any public action or complaints against a licensed physician who has applied or received an expedited license through the compact and any disciplinary or investigatory information as required by Commission rule. Member boards may also report any non-public complaint, disciplinary, or investigatory information not required to be reported to the Commission.

Each member board must report the name, National Provider Identifier (NPI) number, and all necessary and proper disciplinary or investigatory information of a public complaint or action on a form provided by the Commission within 10 business days after a public complaint or action has been entered.[84] Member boards must submit updated reports to the Commission upon changes to the status of any reported action.

All information provided to the Commission or distributed by the member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters. Upon request, member boards may share complaint or disciplinary information about physicians to another member board.

[84] Rule 6.3 of the IMLCC Rules, available at https://imlcc.org/wp-content/uploads/2018/12/IMLCC-Rule-Chapter-6-Coordinated-Information-System-Joint-Investigations-and-Disciplinary-Actions-Adopted-November-16-2018.pdf (last visited January 8, 2024). "Necessary and proper disciplinary and investigatory information" includes type of action, date action was taken, whether the action results in removal of the physician's Compact license, whether the action is to initiate a joint investigation, name of Board or entity that took action, and current status and changes in status of any action.

Effect of the bill - Interstate Medical Licensure Compact

The bill requires Florida to join the Interstate Medical Licensure Compact by adopting the entirety of the compact terms into state law. Florida physicians will be able to obtain expediated licensure in compact member states. Likewise, eligible physicians in compact member states will be able to obtain expedited licensure in Florida.

The bill also requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

Physical Therapy Licensure Compact

Physical Therapy Licensure in Florida

The Physical Therapy Practice Act is codified in chapter 486, F.S. Licensed physical therapist are regulated by the Board of Physical Therapy Practice (Board) within in DOH.[85] A physical therapist must practice physical therapy in accordance with the provisions of the practice act and Board rules.[86] The practice of physical therapy includes:[87]

- The performance of physical therapy assessments;
- The treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other health condition, and the rehabilitation of such disability, injury, disease, or other health condition by alleviating impairments, functional movement limitations, and disabilities by designing, implementing, and modifying treatment interventions through use of:
    - Therapeutic exercise;
    - Functional movement training in self-management and in-home, community, or work integration or reintegration;
    - Manual therapy;
    - Massage;
    - Airway clearance techniques;
    - Maintaining and restoring the integumentary system and wound care;
    - Physical agent or modality;
    - Mechanical or electrotherapeutic modality;
    - Patient-related instruction;
    - The use of apparatus and equipment in the application of the above;
- The performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or
- The performance of electromyography as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine.

To be eligible for licensure as a physical therapist (PT), an applicant must:[88]

Be 18 years of age;
Be of good moral character; and
Satisfy the following educational requirements:

- Have graduated from a school of physical therapy which has been approved for the educational preparation of physical therapists by the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation or the U.S. Department of Education at the time of her or his graduation and have passed, to the

[85] Section 486.023, F.S.
[86] Sections 486.031 and 486.102, F.S.
[87] Section 486.021(11), F.S.
[88] Section 486.031, F.S.

satisfaction of the Board, the American Registry Examination prior to 1971 or a national examination approved by the Board to determine her or his fitness for practice as a physical therapist;
- Have received a diploma from a program in physical therapy in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapists in this country, as recognized by the appropriate agency as identified by the Board, and have passed to the satisfaction of the Board an examination to determine her or his fitness for practice as a physical therapist;[89] or
- Be entitled to licensure without examination.

Physical Therapist Assistant Licensure

A physical therapist assistant (PTA) is an individual who performs patient-related activities, including the use of physical agents, under the direction of a physical therapist.[90] To be licensed as a PTA an applicant must:[91]

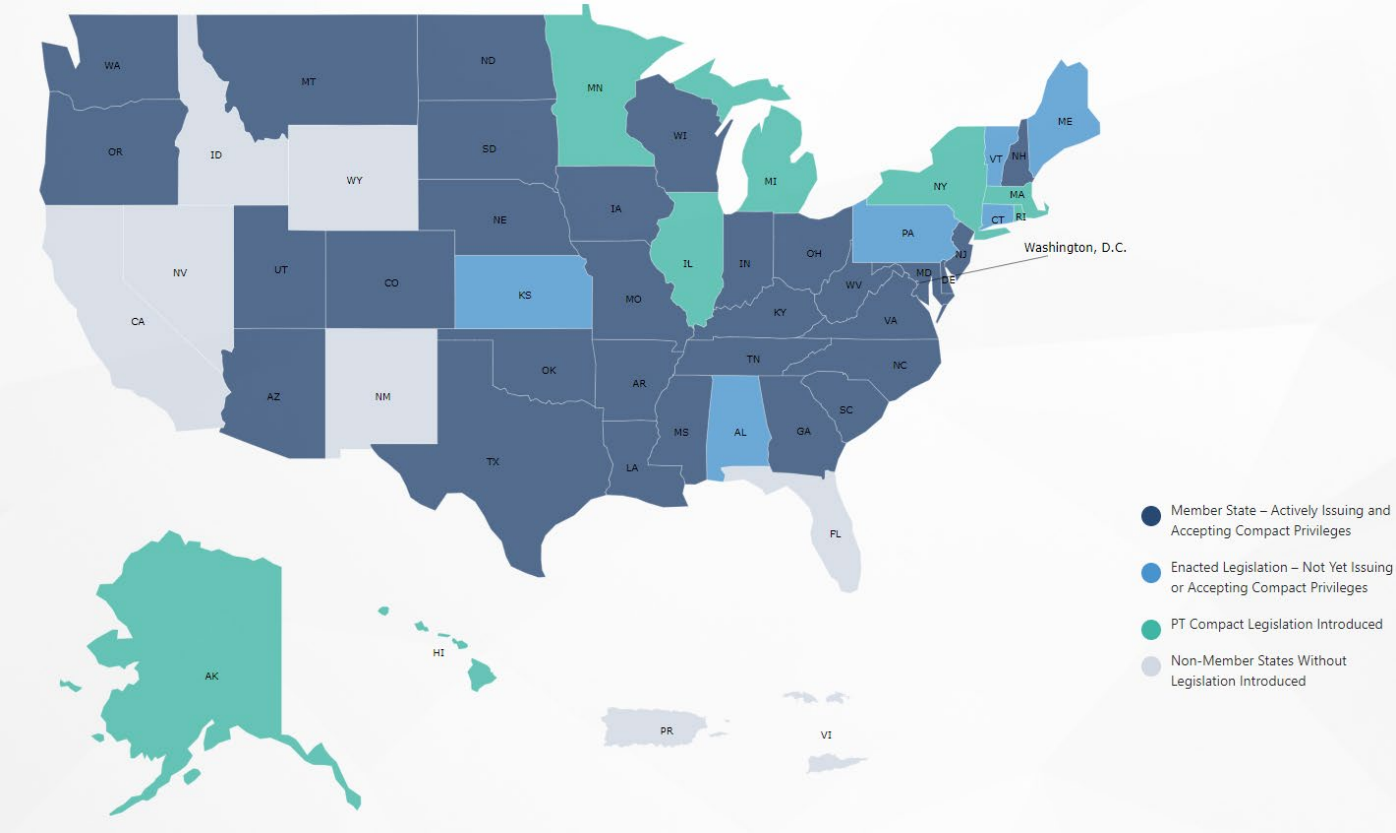
- Be at least 18 years old;
- Be of good moral character; and
- Have graduated from a school that provides at least a two-year course of study for the preparation of physical therapist assistants and is recognized by the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation or the U.S. Department of Education at the time of graduation and have passed a board-approved examination to determine his or her fitness to practice; or
- Have graduated from a school that provides a course for physical therapist assistants in a foreign country that has educational credentials that have been deemed equivalent to the requirements in this country, as recognized by the agency, as identified by the board, and have passed a board-approved examination to determine his or her fitness to practice;
- Be entitled to licensure without examination as provided in section 486.107, F.S., or
- Have been enrolled between July 1, 2014, and July 1, 2016, in a physical therapist assistant school in this state which was accredited at the time of enrollment; and have graduated or is eligible to graduate from such school by July 1, 2018, and have passed a board-approved examination to determine his or her fitness to practice.

The board may issue a PTA license to an applicant who presents evidence to the board, under oath, of licensure in another state, the District of Columbia, or a territory, if the board determines that standards for registering or licensing of a physical therapist assistant in such other state are as high as the standards of this state.[92]

Physical Therapy Licensure Compact

The Physical Therapy Licensure Compact (PT Compact or compact) is a mutual recognition licensure compact that allows a physical therapist who holds a license in their home state to apply for a “compact privilege” to practice in another state. Compact privilege also authorizes a physical therapist licensed by a home state to practice telehealth in member states. Currently, there are thirty-seven (37) compact member states, with thirty-one (31) of those states issuing compact privileges.[93]

[89] Section 486.081, F.S.
[90] Section 486.021(6), F.S.
[91] Section 486.102, F.S.
[92] Section 486.107, F.S.
[93] PT Compact, *Compact Map*, available at https://ptcompact.org/ptc-states, (last visited January 8, 2024).



To exercise compact privilege under the PT Compact, PTs and PTAs must meet all of the following requirements:

- Hold a license in the home state;
- Have no encumbrance on any state license;
- Be eligible for compact privilege in all member states;
- Have no adverse actions taken against the license or compact privilege within the preceding two (2) years;
- Notify the Physical Therapy Compact Commission that the licensee is seeking compact privilege within a remote state;
- Pay any applicable fees, including any state fee, for the compact privilege;
- Meet any jurisprudence requirement established by the remote state in which the licensee is seeking compact privilege; and
- Report any adverse action taken by any nonmember state to the Physical Therapy Compact Commission within 30 days after the action is taken.

To maintain compact privilege, the licensee must continue to meet all of the requirements above in the remote state. A licensee providing physical therapy in a remote state must also comply with the laws and rules of that state and are subject to that state's regulatory authority.

Compact privilege is valid until the expiration date for the home license and is renewable upon renewal of the home state license. If the home state license is encumbered, the licensee shall lose compact privilege to practice in all remote states until the home state license is no longer encumbered and two (2) years have passed since the adverse action.

State Participation in the Physical Therapy Licensure Compact

Under the PT Compact, a member state must grant compact privilege to a licensee holding a valid unencumbered license in another member state. To participate in PT Compact, states must meet all of the following requirements:

- Participate fully in the Physical Therapy Compact Commission (Commission) data system, including using the Commission's unique identifier;
- Have a mechanism in place for receiving and investigating complaints about licensees;[94]
- Notify the commission of any adverse action or the availability of investigative information regarding a licensee;
- Require a criminal background check, including the submission of fingerprints or other biometric-based information, as condition of licensure;
- Comply with Commission rules;
- Require the licensee to pass a recognized national examination as a requirement for licensure;
- Have continuing competence requirements as a condition for license renewal;

Physical Therapy Compact Commission

The PT Compact establishes the Physical Therapy Compact Commission as the governing body and the entity responsible for creating and enforcing the rules and regulations of the compact. Each member state may delegate one member, selected by that member state's physical therapy licensing board, to serve on the Commission. The compact requires the Commission to establish and elect an executive board to act on behalf of, and within the powers granted to them by, the Commission.

All Commission meetings must be open to the public and public notice must be given. However, the Commission or the executive committee or other committees of the Commission may convene in a closed non-public meeting if confidential or privileged information must be discussed. Nothing in the compact shall be construed to be a waiver of sovereign immunity.

Shared Data System

The PT Compact requires the Commission to develop and maintain a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states. Compact member states must submit certain licensure information to the data system on all PTs and PTAs to whom the compact applies, including identifying information, licensure data, and any adverse actions taken against the PT or PTA's license or compact privilege. Investigative information pertaining to a licensee in any member state must be available to other member states. A member state may designate information submitted to the data system that may not be shared with the public without the express permission of that member state.

Effect of the bill - Physical Therapy Licensure Compact

The bill requires Florida to join the Physical Therapy Licensure Compact. The bill authorizes eligible licensed Florida PTs and PTAs to obtain a compact privilege to provide services to out-of-state patients in person or through telehealth in compact member states. It also allows out-of-state licensed PTs and PTAs in member states with a Florida compact privilege to provide services to Floridians via telehealth and in-person.

[94] Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations, including physical therapist and physical therapist assistants under the Division of Medical Quality Assurance in DOH. Section 456.072, F.S., specifies acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Section 486.125, F.S., identifies acts that constitute grounds for which disciplinary actions may be taken against a physical therapist or a physical therapist.

The bill amends current law to allow compact implementation. The bill also requires the Board of Physical Therapy Practice to submit certain specified information on all licensed PTs and PTAs under the compact to a shared data system, including, identifying information, licensure data, and any adverse actions taken against the PT or PTA's license. It requires PTs and PTAs to withdraw from all practice under the compact if the PT or PTA is in an impaired practitioner program. The bill also exempts out-of-state licensed PTs and PTAs who practice under the compact from licensure requirements in this state. The bill authorizes the Board to take adverse action against a licensed PT or PTA's compact privilege and impose disciplinary actions for violation of prohibited acts.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill preserves the regulatory authority of the state's current system of state licensure.

Licensure of Physicians of Foreign-Trained Physicians

Chapter 458, F.S., provides for the licensure and regulation of the practice of allopathic medicine by the Florida Board of Medicine within the Department of Health (DOH). The chapter imposes requirements for licensure examination and licensure by endorsement.[95]

Licensure by Examination

An individual seeking to be licensed by examination as a physician must meet the following requirements:[96]

- Be at least 21 years of age;
- Be of good moral character;
- Not have committed an act or offense that would constitute the basis for disciplining a physician under s. 458.331, F.S.;
- Completed two years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry prior to entering medical school;
- Graduated from an allopathic medical school recognized and approved by an accrediting agency recognized by the U.S. Office of Education or recognized by an appropriate governmental body of a U.S. territorial jurisdiction;
- Completed at least one year of approved residency training; and
- Obtained a passing score on:
    - The United States Medical Licensing Examination (USMLE);
    - A combination of the USMLE, the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or
    - The Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX), if the applicant was licensed on the basis of a state board examination, is currently licensed in at least one other jurisdiction of the United States or Canada, and has practiced for a period of at least 10 years.

[95] An individual who holds an active license to practice medicine in another jurisdiction may seek licensure by endorsement to practice medicine in Florida in lieu of examination. The applicant must meet the same requirements for licensure by examination. To qualify for licensure by endorsement, the applicant must also submit evidence of the licensed active practice of medicine in another jurisdiction for at least 2 of the preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure. S. 458.313(1)(c), F.S.

[96] Section 458.311(1), F.S.

Licensure by Examination – Foreign-Trained Applicant

Foreign-trained applicants must meet the same requirements as U.S.-trained applicants related to age, character, background checks, prior disciplinary action, completion of post-secondary education and obtaining a passing score on the USMLE, FLEX or SPEX, as applicable. Applicants who graduated from an allopathic foreign medical school registered with the World Health Organization and certified pursuant to statute as meeting the standards required to accredit U.S. medical schools, are required to have completed at least one year of an approved residency training.[97] Applicants who graduated from an allopathic foreign medical school that has not been certified pursuant to statute must have:

- An active, valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG);
- Passed the ECFMG's examination; and
- Completed an approved residency or fellowship of at least 2 years in one specialty area.

Residency Programs

A residency, also called graduate medical education, is a training program that medical students and international medical school graduates must complete at a postgraduate hospital. The duration of the program varies in length from three to eight years depending on the specialty.[98] While in a residency program, residents train in a specialty or core program (e.g., general surgery, pediatrics, or internal medicine). The residency placement occurs during the final year of medical school. Residents are matched to a program based on certain criteria including resident preference for a particular specialty, aptitude based on medical school grades and performance in rotations, and available residency positions or slots.[99]

In Florida an approved one-year residency consists of a course of study and training in a single program for a period of at least 12 months by a medical school graduate (resident).[100] The hospital and the program in which the resident is participating must be accredited for the training and teaching of physicians by the Accreditation Council for Graduate Medical Education (ACGME), College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC) and the resident must be assigned an allocated position or slot[101] approved by the ACGME, CFPC or RCPSC.[102]

Similarly, an approved two-year residency in one specialty area consists of two progressive years in a course of study and training as long as each year is accepted by the American Board of Medical Specialties in that specialty for at least twenty-four months by a medical school graduate. The hospital and the program in which the resident is participating must meet the same accreditation and slot assignment requirements as an approved one-year residency.[103]

As noted above, foreign-trained applicants are required to complete a 1-year or 2-year approved residency to become licensed in Florida. The Florida Board of Medicine (BOM) limits the approved residencies to those accredited by the ACGME, CFPC and the RCPSC. These entities only accredit

[97] Id.
[98] USMLE Courses, *Residency & Match,* at https://www.usmle-courses.eu/residency-match/ (last visited January 8, 2024).
[99] OPPGA, *Florida's Graduate Medical Education System,* Report No. 14.08, February 2014 at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/__physician-workforce-development-and-recruitment/additional-council-resources/OPPAGAGMERepor14-08February2014.pdf (last visited January 8, 2024).
[100] 64B8-4.004 F.A.C.
[101] A residency position or slot refers to federally supported residency training slots. These slots are typically funded through Medicare Graduate Medical Education Payments, which cover Medicare's share of the costs of a hospital's approved medical residency program. These costs include direct costs of operating a residency program, such as resident stipends, supervisory physician salaries, and administrative costs. In fiscal year 2020, Medicare paid $16.2 billion for medical residency training. See Congressional Research Service, *Medicare Graduate Medical Education Payments: An Overview.,* September 29, 2022 at https://crsreports.congress.gov/product/pdf/IF/IF10960, (last visited January 8, 2024).
[102] Rule 64B8-4.004, F.A.C.
[103] Id.

U.S. and Canadian medical residencies. Thus, a foreign-trained physician who did not complete a U.S. or Canadian residency is required to complete an additional residency irrespective of how long they may have practiced medicine and whether they previously completed a residency in another country.

Certification of Foreign Educational Institutions

Section 458.314, F.S., allows for the evaluation and certification of foreign medical schools that provide an education that is reasonably comparable to that of similar accredited institutions in the U.S. and which adequately prepares its students for the practice of medicine. Foreign medical schools are certified by DOH. To be considered for certification a foreign medical school must submit an application to DOH and complete the certification process outlined in Rule 64B8-14.003, F.A.C.

Effect of the bill - Licensure of Physicians of Foreign-Trained Physicians

The bill removes the current law requirement for foreign-trained physicians to complete an approved residency program in the U.S. to obtain a license to practice medicine in Florida and creates an alternative licensing requirement for graduates of a foreign medical school. Specifically, the bill allows a graduate of a foreign-trained medical school to forgo completion of an approved residency if the applicant meets all meets all of the following criteria:

- Holds an active, unencumbered license to practice medicine in a foreign country;
- Has actively practiced medicine in the four years preceding the date in which the foreign graduate submitted an application to obtain licensure;
- Has completed a residency or substantially similar postgraduate medical training in a country recognized by his or her licensing jurisdiction; or
- Has an offer for full-time employment as a physician from a health care provider that operates in Florida, and maintains employment with the employer, or another health care provider in Florida, for two consecutive years after licensure. The physician must notify the board within five days after any change of employer.

The foreign-trained applicant must still meet all other statutory requirements for licensure, including having graduated from a foreign medical school that provides an educational program reasonably comparable to that of similarly accredited institutions in the U.S.

For foreign medical schools that do not complete the certification process, the bill authorizes the Board of Medicine to exclude the foreign medical school from being considered an institution that provides medical education that is reasonably comparable to similar accredited institutions in the U.S.

Temporary Certificates for Practice in Areas of Critical Need

Areas of Critical Need

The Surgeon General is responsible for determining areas of critical need in the state.[104] The determination by the Surgeon General defines the areas of the state wherein a physician may be issued a temporary certificate to practice in areas of critical need. The determination also includes a provision which allows physicians with an active temporary certificate for practice in an area of critical need to continue to practice under the certificate until it is due for renewal, regardless if the location where the physician practices loses its HPSA designation.[105] In August 2022, the Surgeon General

[104] Sections. 458.315(3)(a) and 459.0076(3)(a), F.S.
[105] *Supra*, note 108.

determined that all mental health and primary care Health Professional Shortage Areas (HPSA),[106] Volunteer Health Care Provider participants,[107] and free clinics are areas of critical need.[108]

Temporary Certificates for Practice in Areas of Critical Need

A temporary certificate allows a qualified physician to provide services in certain settings in areas of critical need without undergoing the process of obtaining full licensure to practice in Florida.

The Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) may issue a temporary certificate to practice in an area of critical need to a physician[109] with an active license to practice in any United States jurisdiction[110] who will:[111]

- Practice in an area of critical need;
- Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state; or
- Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

The BOM and the BOOM are authorized to administer an abbreviated oral examination to determine a physician's competency. A written examination is not required.[112] The boards must review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification within 60 days after the receipt of the application.[113] The boards may not issue a temporary certificate to a physician who is under investigation in any jurisdiction in the US for an act which would constitute a violation of the relevant practice act.[114]
A temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.[115] However, the boards must review the temporary certificate holder at least annually to ensure that he or she is in compliance with the practice act and rules adopted thereunder.[116] A board may revoke or restrict the temporary certificate for practice in areas of critical need if noncompliance is found.[117]

There are currently 934 physicians with active temporary certificates to practice in areas of critical need.[118] The BOM and the BOOM are not authorized under current law to issue temporary certificate

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[106] HRSA, *What is Shortage Designation?* (2023). Available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas (last visited January 8, 2024).
[107] S. 766.1115, F.S. *See also*, Florida Department of Health, *The Volunteer Healthcare Provider Program Online Listing of Participating Providers*. Available at https://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-provider-listing/index.html (last visited January 8, 2024).
[108] Florida Department of Health, Determination of Areas of Critical Need Pursuant to Sections 458.315 and 459.0076, Florida Statutes (2022). Available at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/DeterminationofAreasofCriticalNeed-8-10-22.pdf (last visited January 8, 2024).
[109] Allopathic physicians are licensed and regulated by the Board of Medicine (BOM), pursuant to Ch. 458, F.S. Osteopathic physicians are licensed and regulated by the Board of Osteopathic Medicine (BOOM), pursuant to Ch. 459, F.S.
[110] Sections 458.315 and 459.0076, F.S.
[111] Sections 458.315(2) and 459.0076(2), F.S.
[112] Sections 458.315(3)(d) and 459.0076(3)(d), F.S.
[113] *Id.*
[114] Sections 458.315(2) and 459.0076(2), F.S.
[115] Sections 458.315(3) and 459.0076(3), F.S.
[116] *Id.*
[117] *Id.*
[118] Correspondence from the Department of Health to Health and Human Services Committee staff dated December 14, 2023. On file with the Health and Human Services Committee.

for practice in areas of critical need to physician assistants.[119] Likewise, the Board of Nursing (BON) is not authorized to issue temporary certificates to practice in areas of critical need to advanced practice registered nurses (APRNs).

Physician Assistants and APRNs

Physicians assistants (PA) and APRNs are non-physician advanced practice providers, sometimes considered "physician extenders."[120] PAs and APRNs are able to complement the physician workforce in a manner that expands the capacity of a health care system while ensuring safe and efficient patient care.[121] The role of PAs and APRNs is especially important in areas experiencing a shortage of health care providers.

PA is a health care practitioner who practices under the direct or indirect supervision of an allopathic or osteopathic physician. PAs may provide a number of medical services including:[122]

- Physical examinations;
- Diagnosis and treatment of illness;
- Counsel on preventative health care;
- Assistance in surgery; and
- Prescribing of medication.

PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.[123] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[124] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than ten PAs at any time.[125]

An APRN is a licensed professional nurse who is additionally licensed in an advanced nursing practice, including certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric nurses.[126] In addition to the practice of professional nursing,[127] APRNs perform advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[128] APRNs are also authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[129]

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[119] In Florida, PAs are governed by the respective physician practice act governing the physician under which they practice. As such, PAs are governed by either ch. 458, F.S., if they practice under an allopathic physician, or by ch. 459, F.S., if they practice under an osteopathic physician.
[120] Milewski, M.D., Coene, R.P., Flynn, J.M., Imrie, M.N., Annabell, L., Shore, B.J., Dekis, J.C., Sink, E.L. (2022). *Better Patient Care Through Physician Extenders and Advanced Practice Providers*. Journal of Pediatric Orthopaedics 42, 18-S24. DOI: 10.1097/BPO.0000000000002125
[121] Johal, J., & Dodd, A. (2017). Physician extenders on surgical services: a systematic review. Canadian journal of surgery. Journal canadien de chirurgie, 60(3), 172–178. https://doi.org/10.1503/cjs.001516
[122] Florida Academy of Physician Assistants, *What is a PA*? Available at https://www.fapaonline.org/page/whatisapa (last visited January 8, 2024).
[123] Sections 458.347(2)(f), F.S., and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.
[124] Rules 64B8-30.012, F.A.C., and 64B15-6.010, F.A.C.
[125] Sections 458.347(15), F.S., and 459.022(15), F.S.
[126] Section 464.003(3), F.S. In 2018, the Florida Legislature enacted a law which changed the occupational title from "Advanced Registered Nurse Practitioner (APRN)" to "Advanced Practice Registered Nurse (APRN)," and also reclassified a Clinical Nurse Specialist as a type of APRN instead of a stand-alone occupation (*see* ch. 2018-106, Laws of Fla.).
[127] "Practice of professional nursing" means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences. *See* s. 464.003(19), F.S.
[128] Section 464.012(3)-(4), F.S.
[129] Section 464.003, F.S., and s. 464.012, F.S.

Effect of the bill - Temporary Certificates for Practice in Areas of Critical Need

The bill authorizes the BOM and BOOM to issue temporary certificates to practice in areas of critical need to physician assistants under the same specified criteria as required for physicians to practice in those areas under a temporary certificate.

The bill authorizes the BON to issue temporary certificates to practice in areas of critical need to APRNs who hold a valid license in any U.S. jurisdiction and meets the educational and training requirements established by the BON. To be eligible for a temporary certificate an APRN must practice in one of the following settings:

- An area of critical need;
- A county health department; correctional facility;
- A Department of Veterans' Affairs clinic;
- A community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state.

The bill requires the BON to review an application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification within 60 days after the receipt of the application. The BON may administer an abbreviated oral examination to determine an applicant's competency, but may not require a regular, written examination.

The bill prohibits the BON from issuing a temporary certificate to practice in an area of critical need to any APRN who is under investigation in any jurisdiction in the U.S. for an act that would constitute a violation of ch. 464, F.S., until the investigation is complete, at which time disciplinary action may be taken under s. 464.018, F.S.

The bill requires the BON to review each temporary certificate holder at least annually to ascertain that the certificate holder is complying with the minimum requirements of the Nurse Practice Act and its adopted rules. If the BON determines that the certificate holder is not meeting the requirements, the BON must revoke the temporary certificate or impose restrictions or conditions as a condition of continued practice.

An APRN must notify the BON of all approved institutions in which the APRN practices within 30 days of accepting employment. A certificate holder may work for any approved entity in an area of critical need or as authorized by the State Surgeon General.

Graduate Assistant Physician Licensure

Limited Licenses

Both the BOM and the BOOM are authorized to issue limited licenses. Licensed allopathic physicians are issued limited licenses to practice in areas of critical need, and licensed osteopathic physicians are issued limited licenses to practice in areas of critical need or medically underserved areas, though the process and authorizations for each are slightly different.[130]

An allopathic physician wishing to obtain a limited license to practice in the employ of a public or private 501(c)(3) non-profit[131] agency or institution located in a BOM determined area of critical medical need, must submit an application and fee, unless the applicant includes an employer's statement that the position is uncompensated, in which case all fees are waives, and demonstrates that the applicant:

[130] Sections 458.317 and 459.0075, F.S.
[131] Section 501(c)(3) of the Internal Revenue Code.

- Has been licensed to practice medicine in any U.S. jurisdiction for at least 10 years;
- Intends to practice only in areas of critical need; and
- If not fully retired at the time of application, will only practice on an uncompensated basis.

If it has been more than three years since the limited license applicant has been in active practice, the full-time director of the county health department, or a BOM approved licensed physician, must supervise the applicant for six months after licensure, unless the BOM determines that a shorter period will be sufficient. Procedures for such supervision shall be established by the BOM.

The BOOM is also authorized to issue limited licenses to certain osteopathic physicians who will only practice in areas of critical need or in medically underserved areas. A limited license may be issued to an osteopathic physician who:[132]

- Submits the licensure application and required fee;
- Provides proof that he or she has been licensed to practice osteopathic medicine in any U.S. jurisdiction in good standing for 10 years;
- Has completed 40 hours of CME within the preceding two-year period; and
- Will practice only in the employ of public agencies, nonprofit entities, or agencies or institutions in areas of critical need or in medically underserved areas.

If it has been more than three years since the osteopathic limited license applicant has actively practiced medicine, the full-time director of the local county health department must supervise the applicant for at least six months after the issuance of the limited license unless the BOOM determines a shorter period will be sufficient.[133]

The BOOM must review the practice of each osteopathic physician who holds a limited license at least biennially to ensure that he or she is in compliance with the practice act and rules adopted thereunder.[134]

Graduate Medical Education

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.[135] Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.[136]

The National Residency Matching Program (NRMP) matches allopathic and osteopathic medical school graduates to GME programs. The GME application process is competitive and graduates typically apply

[132] Section 459.0075, F.S., and Fla. Admin. Code R. 64B15-12.005 (2023).
[133] Section 459.0075(2), F.S.
[134] Section 459.0075(5), F.S.
[135] *Graduate Medical Education That Meets the Nation's Health Needs*, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited January 8, 2024).
[136] *Id.*

for more than one residency.[137] In 2023, the residency match had a 99% position fill rate.[138] Despite this success rate there are still a significant number of graduates that fail to match. For example, in 2023, there were 3,000 medical school graduates nationwide that failed to match with a GME program.[139] These graduates are unable to provide care to patients until they are matched with a GME program which may take multiple application cycles.

Currently, neither the BOM nor the BOOM are authorized to issue limited licenses to allopathic and osteopathic school graduates who fail to match with a GME program.

Effect of the bill - Graduate Assistant Physician Licensure

The bill authorizes the BOM and BOOM to issue a graduate assistant physician (GAP) license to a graduate of an allopathic or osteopathic medical school who has not matched with a GME program. The BOM and the BOOM, respectively, must issue a GAP license for a duration of two years to an applicant who meet all of the following:

- Is a graduate of an allopathic or osteopathic medical school or college, as applicable, approved by an accrediting agency recognized by the U.S. Department of Education;
- Has successfully passed all parts of the USMLE for allopathic physicians or the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the BOOM;
- Has not received a residency match from the NRMP within the first year following graduation from medical school;
- Is at least 21 years of age;
- Is of good moral character;
- Has submitted documentation that the applicant has agreed to enter into a written protocol, with specific provisions required by applicable boards rules, drafted by a Florida physician with a full, active, and unencumbered license upon the issuance of the limited license;
- Has submitted a copy of the protocol to the appropriate board;
- Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331 or 459.015, F.S., as applicable; and
- Has submitted to the DOH a set of fingerprints.

The bill prohibits the DOH from issuing a limited license, or the BOM or the BOOM from certifying any applicant for a limited licensure, who is under investigation in another jurisdiction for an offense which would constitute a violation of ch. 456, F.S., orch. 458 and 459, F.S., as applicable; and the applicant is subject to disciplinary action under ss. 458.331 and 459.015. F.S., as appropriate. If a board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under ss. 458.331 or 459.015, F.S, as applicable, the board may enter an order imposing one of the following terms:

- Refusal to certify to the DOH an application for a GAP limited license; or
- Certification to the DOH of an application for a GAP limited license with restrictions on the scope of practice of the licensee.

The bill authorizes a one-time renewal for one additional year of the limited license provided licensee submits to the appropriate board documentation of:

[137] *Graduate Medical Education in Florida,* Office of Program Analysis and Government Accountability, December 2023, available at https://oppaga.fl.gov/Products/ReportDetail?rn=23-GME (last visited on January 6, 2024).
[138] *Id.*
[139] *Medical Students Show Leadership in Call for More GME Slots*, American Medical Association, April 17, 2023 (available at https://www.ama-assn.org/education/gme-funding/medical-students-show-leadership-call-more-gme-slots, last visited on January 6, 2024).

- Actual practice under the required protocol during the initial limited licensure period; and
- Applications he or she has submitted for accredited graduate medical education training programs.

The bill authorizes GAP licensee to only provide health care services under the direct supervision of the board approved Florida physician, with a full, active, and unencumbered license. The supervising physician:

- May supervise no more than two GAP licensees;
- Must be physical presence at the location where the services are rendered; and
- Must draft the protocol to specify the duties and responsibilities of the limited licensed GAP as specified by board rule.

The bill requires the supervising physician to be liable for any acts or omissions of the GAP licensee acting under the physician's supervision and control; and authorizes third-party payors to reimburse employers of a GAP licensee for covered services.

The bill authorizes the BOM and the BOOM to adopt rules to implement these sections.

Medical Faculty Certificates

The BOM may issue medical faculty certificates. Medical faculty certificates allow physicians to practice medicine in Florida without the prerequisite of sitting for and successfully passing a national examination. While they have the same rights and responsibilities as other licensed physicians,[140] physicians issued medical faculty certificates may only practice in conjunction with a full-time faculty position at an accredited medical school and its affiliated clinical facilities or teaching hospitals.[141]

A physician is eligible to receive a medical faculty certificate without examination if they fulfill all of the following prerequisites:[142]

- A graduate of an accredited medical school or its equivalent, or a graduate of a foreign medical school listed with the World Health Organization.
- Hold a valid, current license to practice medicine in another jurisdiction.
- Complete an application form and remit a nonrefundable application fee not to exceed $500.[143]
- Complete an approved residency or fellowship of at least one year or equivalent training.
- Are at least 21 years of age.
- Are of good moral character.
- Have not committed any act in Florida or any other jurisdiction which would constitute the basis for disciplining a physician.
- Complete, before medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by BOM.[144]
- Accept a full-time faculty appointment to teach in a program of medicine at one of the following schools:
    - The University of Florida.

[140] Section 458.3145(3), F.S.
[141] Section 458.3145(2), F.S.
[142] Section 458.3145(1), F.S.
[143] BOM's nonrefundable application fee for medical faculty certificates is $350. If the application is for an initial license, an initial license fee adds another $355 to the total. In addition, BOM charges a Neurological Injury Compensation Association (NICA) Fund fee between $0 and $5,000 depending on practitioner status. For medical faculty certificate applicants who seek authorization to dispense pharmaceuticals, there is a $100 dispensing practitioner fee. Board of Medicine, *Application for Medical Faculty Certificate for Allopathic Physicians*, p. 4 (revised Dec. 2020) https://flboardofmedicine.gov/apps/app-medical-faculty-certificate.pdf (last visited Dec. 13, 2023).
[144] This education requirement is only applicable to applicants who graduated medical school after October 1, 1992. s. 458.3145(1)(h), F.S.

- The University of Miami.
- The University of South Florida.
- The Florida State University.
- The Florida International University.
- The University of Central Florida.
- The Mayo Clinic College of Medicine and Science (Jacksonville).
- The Florida Atlantic University.
- The Johns Hopkins All Children's Hospital (St. Petersburg).
- Nova Southeastern University.
- Lake Erie College of Osteopathic Medicine.

Medical faculty certificates automatically expire when the physician's relationship with the medical school terminates or after a period of 24 months.[145] Medical faculty certificates are renewable every 2 years, but the physician must apply for the renewal and provide certification by the dean of the medical school that the physician is a distinguished medical scholar and an outstanding practicing physician.[146] An annual review of each medical faculty certificate recipient is made by the dean of the certificate recipient's accredited 4-year medical school and reported to BOM.[147]

In any year, the maximum number of extended medical faculty certificate holders may not exceed 30 persons at each medical school.[148] The exception is The Mayo Clinic College of Medicine and Science in Jacksonville where the maximum number of extended medical faculty certificate holders may not exceed 10 persons.[149]

As of August 17, 2023, BOM oversees 58 active number of certificate holders at the following institutions:[150]

Medical School of Teaching Institution	**Medical Faculty Certificate Holders**
H. Lee Moffitt Cancer Center and Research Institute (USF)[151]	0
Florida Atlantic University	0
Florida International University	2
Florida State University	1
Lake Erie College of Osteopathic Medicine	0
Nova Southeastern University	1
The Johns Hopkins All Children's Hospital (St. Petersburg)	0
The Mayo Clinic College of Medicine and Science (Jacksonville)	2
University of Central Florida	0
University of Florida	32
University of Miami	18

[145] Section 458.3145(2), F.S.
[146] *Id*.
[147] Section 458.3145(5), F.S.
[148] Section 458.3145(4), F.S.
[149] *Id*.
[150] Correspondence from Department of Health to Health and Human Services Committee dated December 14, 2023 (on file with the Health and Human Services Committee). Data reflects the number of medical certificate holders employed full-time on August 17, 2023. Thus, this number for any day of the year could be different than the number (70) published in MQA's Annual Report and Long-Range Plan FY22-23.
[151] Sections 458.1345(4), 1004.43, F.S.

University of South Florida	2

For FY22-23, a total of 29 initial medical faculty certificates were issued out of 45 initial applications received.[152] Out of the total 45,352 complaints and 5,246 investigations that MQA's Bureau of Enforcement handled during FY22-23, none involved medical faculty certificates.[153]

Effect of the bill - Medical Faculty Certificates

The bill eliminates the cap on the maximum number of medical faculty certificates that the BOM may issue to eligible physicians.

Restricted Licenses For Certain Experienced Foreign-Trained Physicians

Section 458.3124, F.S., was created in 1997 as path to a restricted license, and ultimately a full Florida license, by permitting foreign trained physicians with five years of experience, who had been residents of Florida since 1986, to apply to the DOH by December 31, 2000, to take the USMLE, Part III. Once the USMLE, Part III, was passed, the restricted licensee practiced under the supervision of a BOM approved licensee with the first year being direct supervision and the second year being indirect supervision in a community service setting.

Effect of the bill - Restricted Licenses For Certain Experienced Foreign-Trained Physicians

The bill repeals the obsolete s. 458.3124, F.S., since that section's applicability to the issuance of restricted medical licenses ended December 31, 2000.

Autonomous APRN Practice

Current law authorizes an APRN who meets certain eligibility criteria to engage in autonomous practice only in primary care, which includes family practices, general pediatrics and general internal medicine, as defined by BON rule and midwifery, without a supervising physician or written protocol with a physician.[154] The BON has defined primary care by rule to include the "physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions."[155]

To engage in autonomous practice, an APRN must hold active and unencumbered Florida or multi-state license and have:

- Completed at least 3,000 clinical practice hours or clinical instructional hours[156] supervised by a physician with an active license within the five-year period immediately preceding the registration request;
- Not have been subject to any disciplinary action during the five years immediately preceding the application;
- Completed three graduate-level semester hours, *or the equivalent*, in pharmacology and three graduate-level semester hours, *or the equivalent,* in differential diagnosis within the five-year period preceding the registration request;[157] and
- Any other registration requirements provided by BON rule.

[152] *See footnote 150*.
[153] *Id*.
[154] Section 464.0123(3)(a)1., F.S.
[155] Fla. Admin. Code R. 64B9-4.001(12), (2023).
[156] The bill defines "clinical instruction" as education provided by faculty in a clinical setting in a graduate program leading to a master's or doctoral degree in a clinical nursing specialty area.
[157] *See* Fla. Admin. Code R. 64B9-4.020(3),(2023) where the BON defined, by rule, *the equivalent of* three graduate-level semester hours in pharmacology and *the equivalent of* three graduate-level semester hours in differential diagnosis as equal to forty-five (45) Continuing Education credits offered in those areas by the entities set forth in Section 464.013(3)(b), F.S. and Fla. Admin. Code R. 64B9-4.002(2), (2023).

An autonomous APRN registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN and RN. To maintain autonomous APRN registration, an autonomous APRN must complete at least 10 hours of BON approved CE for each biennial renewal in addition to the 30 hours of CE required for renewal of the APRN license.[158]

Autonomous Practice by Certified Nurse Midwives (CNM)

CNMs is an APRN who has a specialty certification in midwifery. A CNM provides care during pregnancy, childbirth, and the postpartum period, as well as sexual and reproductive health care, gynecologic health care, and family planning services.[159]

A CNM may perform the following procedures to the extent authorized by the established protocol approved by the health care facility in which they are operating, or by the supervising physician if performing a delivery in a patient's home:[160]

- Perform superficial minor surgical procedures.
- Manage the patient during labor and delivery to include amniotomy, episiotomy, and repair.
- Order, initiate, and perform appropriate anesthetic procedures.
- Perform postpartum examination.
- Order appropriate medications.
- Provide family-planning services and well-woman care.
- Manage the medical care of the normal obstetrical patient and the initial care of a newborn patient.

A CNM who is registered to practice autonomously may only perform midwifery services[161] if they have a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician.[162] CNMs have encountered difficulty obtain written referral agreements from physicians. Currently, only 83 of the 1,202 licensed CNMs in Florida are registered for autonomous practice.[163]

Effect of the bill - Autonomous Practice by Certified Nurse Midwives (CNM)

The bill revises the requirements under which an autonomous CNM may provide out-of-hospital intrapartum care. The bill outlines specific safety procedures that must be in place before an autonomous CNM may provide out-of-hospital intrapartum care, and eliminates the existing requirement that an autonomous CNM have a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician to do so.

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[158] Current law provides an exception to the 10 hours of CE in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.
[159] American College of Nurse-Midwives, *Definition of Midwife and Scope of Practice of Certified Nurse-Midwives and Certified Midwives*. Available at https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007476/Definition%20Midwifery%20Scope%20of%20Practice_2021.pdf (last visited January 8, 2024).
[160] S. 464.012(4)d), F.S.
[161] *See* s. 464.012(4)(c), F.S.
[162] S. 464.0123(3)(b), F.S.

As a condition precedent to providing out-of-hospital intrapartum care, a CNM engaged in autonomous practice must maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services. The written policy must include an emergency plan-of-care form to be signed by the patient before admission. The plan-of-care form must contain:

- The name and address of the closest hospital that provides maternity and newborn services;
- Reasons for which transfer of care would be necessary, including the transfer-of-care conditions prescribed by BON rule; and
- Ambulances or other emergency medical services that would be used to transport the patient in the event of an emergency.

When an emergency transfer of care is required, the bill requires an autonomous CNM provide the receiving provider with the patient's emergency plan-of-care form, and the patient's prenatal records including patient history, prenatal laboratory results, sonograms, prenatal care flow sheets, maternal fetal medical reports, and labor flow charting and current notations; and it requires an autonomous CNM to provide the receiving provider with a verbal summary of the information on the patient's emergency plan-of-care form, and make himself or herself immediately available for consultation.

The bill authorizes the BON to adopt rules to prescribe transfer-of-care conditions, monitor for excessive transfers, conduct reviews of adverse maternal and neonatal outcomes, and monitor the licensure CNMs engaged in autonomous practice.

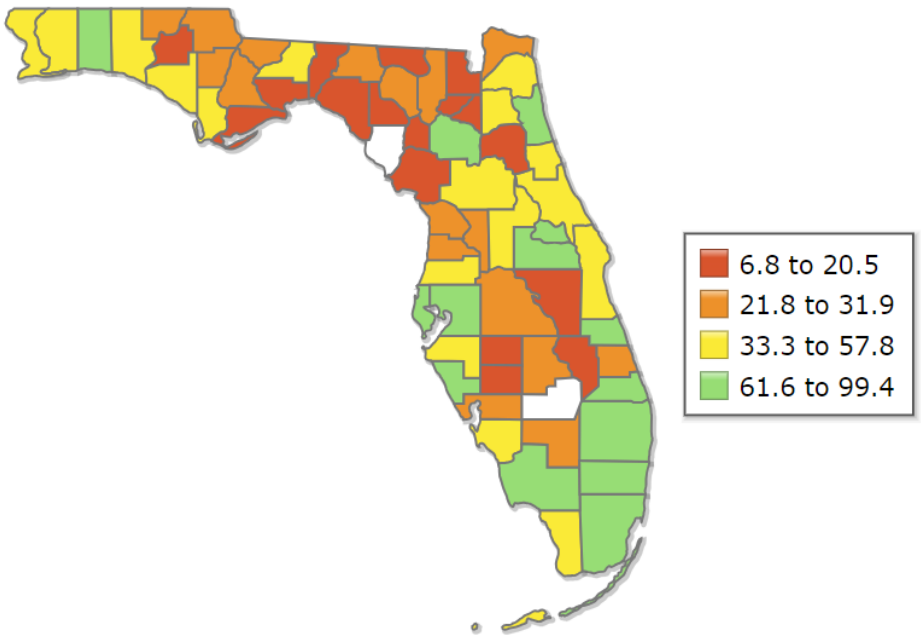
Dental Student Loan Repayment Program

Access to Dental Care and Dental Workforce in Florida

There are 7,651 dental HSPAs in the U.S., 266 of which are in Florida.[164] In 2022, there were approximately 59 licensed dentists per 100,000 people in Florida; however, this ratio varies greatly across the state. Most dentists are disproportionately concentrated in the more populous areas of the state. Two counties, Dixie and Glades, do not have any licensed dentists.[165]

[164] Florida Department of Health, FL Health Charts, available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=326 (last visited January 8, 2024)
[165] Id.

Licensed Dentists per 100,000 Floridians FY 2021-2022[166]



There is a noticeable shortage of dentists in certain parts of the state, especially the central Panhandle counties and interior counties of south Florida.[167] Lower patient densities, rural income disparities, and lower dental care reimbursement levels make it difficult to recruit and retain dentists in rural communities of the state.[168] Lack of access to dental care can lead to poor oral health and poor overall health.[169] Research has shown a link between poor oral health and diabetes, heart and lung disease, stroke, respiratory illnesses, and adverse birth outcomes including the delivery of pre-term and low birth weight infants.[170]

Dental Student Loan Repayment Program

In 2019, the Legislature created the Dental Student Loan Repayment Program under DOH. Under the program, a Florida-licensed dentist is eligible to participate if he or she maintains active employment in a public health program[171] that serves Medicaid recipients and other low-income patients and is located in a dental HSPA or a MUA.[172]

A dentist is no longer eligible to receive funds under the Loan Program if the dentist:[173]

- Is no longer employed by a public health program that is located in a dental HSPA or a MUA and serves Medicaid recipients and other low-income patients;

[166] Id.
[167] Id.
[168] Chris Collins, MSW, *Challenges of Recruitment and Retention in Rural Areas*, North Carolina Medical Journal, Vol. 77 no. 2, (March-April 2016), http://www.ncmedicaljournal.com/content/77/2/99.full (last visited January 8, 2024).
[169] Florida Department of Health, *Florida's Burden of Oral Disease Surveillance Report*, (Aug, 2016), p. 5, *available at*, http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/floridas-burden-oral-disease-surveillance-report.pdf (last visited January 8, 2024).
[170] *Id.*
[171] Section 381.4019 defines a "public health program" as a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by DOH.
[172] Section 381.4019, F.S.
[173] *Id.*

- Ceases to participate in the Florida Medicaid program; or
- Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of the dental practice act.

DOH is authorized to award each eligible dentist up to $50,000 in student loan repayments per year for up to five years, for a maximum of $250,000. DOH may approve up to 10 new dentists each fiscal year to participate in the Loan Program, in addition to those dentists already participating in the Loan Program.[174]
The Loan Program may only cover loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses and must be made directly to the holder of the loan. All repayments are contingent upon continued proof of eligibility and the state is not responsible for the collection of any interest charges or other remaining loan balances.[175]

Currently, there is no reporting requirement and no requirement to perform an evaluation on the effectiveness of the program.

Effect of the bill - Dental Student Loan Repayment Program

The bill expands eligibility for the Dental Student Loan Repayment Program to include dental hygienists and to include dentists who practice in private dental practices that are located in dental health professional shortage areas. The annual award for a qualifying dentists or dental hygienist is 20 percent of his or her principal loan amount at the time that he or she applies for the program, but may not be more than $50,000 per year for dentists or $7,500 per year for dental hygienists.

The bill requires practitioners to provide 25 hours of volunteer primary care or dental services in a free clinic, as defined in s. 766.1115, F.S., that is located in an underserved area or through another volunteer program operated by the state pursuant to part IV of ch. 110, F.S.

Additionally, the bill requires AHCA to seek federal authority to use Title XIX[176] matching funds for the Dental Student Loan Repayment Program and provides a sunset date for the program of July 1, 2034.

The bill creates s. 381.4021, F.S., to establish reporting requirements for the program. The bill requires DOH to provide an annual report to the Governor and the Legislature that details:

- The number of applicants for loan repayment;
- The number of loan payments made under each program;
- The amounts for each loan payment made;
- The type of practitioner to whom each loan payment was made;
- The number of loan payments each practitioner has received under either program; and
- The practice setting in which each practitioner who received a loan payment practices.

The bill also requires DOH to contract with an independent third party to develop and conduct a study to evaluate the effectiveness the DSLR Program. The bill requires DOH to begin collecting the data needed by January 1, 2025, and submit the study to the Governor and the Legislature by January 1, 2030. Practitioners who receive payments under the DSLR Program must furnish any information requested by DOH for the study or DOH's annual reporting requirements.

[174] *Id.*
[175] *Id.*
[176] Title XIX of the federal Social Security Act creates the Medicaid program and provides federal matching funds for states that participate in Medicaid.

The Florida Reimbursement Assistance for Medical Education Program (FRAME)

In 2002, the Legislature created the Medical Education Reimbursement and Loan Repayment Program (program) within DOH, to encourage health care professionals to practice in underserved areas where there are shortages of such personnel.[177] The program makes payments to offset loans and educational expenses incurred in nursing or medical studies or licensure. Health care professionals eligible to participate in the program include:[178]

- Allopathic physicians with primary care specialties;
- Osteopathic physicians with primary care specialties;
- Physician assistants;
- Autonomous APRNs with primary care specialties;
- Licensed practical nurses;
- Registered nurses; and
- APRNs.

As funds are available, DOH may award up to:[179]

- $20,000 per year for allopathic and osteopathic physicians with primary care specialties;
- $15,000 per year for autonomous APRNs with primary care specialties;
- $10,000 per year for APRNs and physician assistants; and
- $4,000 per year for licensed practical nurses and registered nurses.

To qualify for reimbursement, a health care practitioner must:[180]

- Be a U.S. citizen;
- Possess a clear active Florida health care professional license;
- Provide in-person services to persons in an underserved location;[181]
- Not have received an award from any other State of Florida-funded student loan repayment program since July 1 of the previous year; and
- Have a qualified loan.[182]

An autonomous APRN, in addition to the requirements above, must specifically have active employment providing primary care services in a practice or public health program that serves Medicaid and other low-income patients and practice in a location that has a primary care Health Professional Shortage Area (HPSA)[183] score of at least 18.[184]

[177] Section 1009.65(1), F.S.
[178] Id. Primary care specialties for physicians include obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties identified by DOH.
[179] Section 1009.65(1), F.S.
[180] Rule 64W-4.002(1)(a), F.A.C.
[181] Rule 64W-4.001, F.A.C., defines an "underserved location" as a public health program; a correctional facility; a Health Professional Shortage Area as designated by Federal Health Resources and Services Administration in a primary care discipline; a rural area as identified by the Federal Office of Rural Health Policy; a rural hospital as defined in s.395.602(2)(b), F.S.; a state hospital; or other state institutions that employ medical personnel.
[182] Rule 64W-4.001, F.A.C., defines a "qualified loan" as a federal and/or private student loan with a US-based lender that has a verified balance remaining which loan proceeds were used to pay educational expenses.
[183] S. 1009.65(1)(b)1., F.S., defines "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration or a rural area as defined by the Federal Office of Rural Health Policy.
[184] Rule 64W-4.002(1)(b), F.A.C.

During the 2022-2023 fiscal year, 3,702 applications were submitted for loan reimbursement. Of the 3,702 applicants, 1,407 met the program requirements, representing $40.8 million in requested loan forgiveness, which is more than twice the available funding for the program—$16 million. Of the 1,407 applicants who met the program requirements, 1,097 received loan reimbursement awards.[185] Physicians received 81% of the available funding.[186] In determining which applicants receive awards, DOH computes a Frame Prioritization Score using an adjusted HPSA score for the practice location of the provider and the length of employment for the provider.[187]

Currently, there is no reporting requirement and no requirement to perform an evaluation on the effectiveness of the program.

Effect of the bill - The Florida Reimbursement Assistance for Medical Education Program (FRAME)

The bill expands the list of eligible practitioners to include mental health professionals, such as licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists. The bill consolidates autonomous APRNs with the other practitioner types and eliminates specific requirements for such APRNs to qualify for the program. The bill allows reimbursement awards to be provided over a four-year period, instead of on a yearly basis and increases the maximum award amounts for each type of practitioner to up to:

- $150,000 for physicians;
- $90,000 for Autonomous APRNs;
- $75,000 for APRNs and PAs;
- $75,000 for mental health professionals; and
- $45,000 for LPNs and RNs.

A practitioner may only receive an award for one four-year period. At the end of each year that a practitioner participates in the program, DOH must award 25 percent of the practitioner's principal loan amount at the time he or she applied for the program.

The bill requires practitioners to provide 25 hours of volunteer primary care in a free clinic that is located in an underserved area or through another volunteer program operated by the state.

The bill requires AHCA to seek federal authority to use Title XIX matching funds for FRAME, and provides a sunset date of July 1, 2034.

The bill creates s. 381.4021, F.S., to establish reporting requirements for the program. The bill requires DOH to provide an annual report to the Governor and the Legislature that details:

- The number of applicants for loan repayment;
- The number of loan payments made under each program;
- The amounts for each loan payment made;
- The type of practitioner to whom each loan payment was made;
- The number of loan payments each practitioner has received under either program; and
- The practice setting in which each practitioner who received a loan payment practices.

[185] Presentation by Emma Spencer, PhD, MPH, Department of Health, on Student Loan Repayment Programs, Florida House of Representatives, Healthcare Regulation Subcommittee, November 16, 2023, at pgs.7-9, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3246&Session=2024&DocumentType=Meeting+Packets&FileName=hrs+11-16-23.pdf (last visited January 8, 2024).
[186] Id. Physicians received $12,897,865, APRNs received $1,763,773, physician assistants received $512,249, registered nurses received $449,971, autonomous APRNs received $302,079, and licensed practical nurses received $73,950.
[187] Rule 64W-4.005(2), F.A.C.

The bill also requires DOH to contract with an independent third party to develop and conduct a study to evaluate the effectiveness the program. The bill requires DOH to begin collecting the data needed by January 1, 2025, and submit the study to the Governor and the Legislature by January 1, 2030. Practitioners who receive payments under the program must furnish any information requested by DOH for the study or DOH's annual reporting requirements.

Clinical Psychologists' and Psychiatric Nurses' Authority Under the Baker Act

The Florida Mental Health Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [188] The Baker Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[189] Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[190]

Involuntary Examination

An involuntary examination is required if there is reason to believe that the person has a mental illness and, because of his or her mental illness, has refused voluntary examination, is likely to refuse to care for himself or herself to the extent that such refusal threatens to cause substantial harm to his or her well-being and such harm is unavoidable through help of willing family members or friends, or will cause serious bodily harm to himself or herself or others in the near future based on recent behavior.[191]

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[192]
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[193] or
- A physician, clinical psychologist,[194] psychiatric nurse,[195] an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the practitioner's observations supporting such conclusion.[196]

Involuntary patients must be taken to either a public or private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency

[188] Sections 394.451-394.47892, F.S.
[189] Section 394.459, F.S.
[190] Sections 394.4625, 394.463, and 394.4655, F.S.
[191] Section 394.463(1), F.S.
[192] Section 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[193] Section 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.
[194] Section 394.455(5), F.S., defines a "clinical psychologist" as a Florida-licensed psychologist with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the U.S. Department of Veterans Affairs that qualifies as a receiving or treatment facility.
[195] Section 394.455(36), F.S., defines a "psychiatric nurse" as a Florida-licensed advanced practice registered nurse who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.
[196] Section 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.

conditions for psychiatric evaluation and to provide short-term treatment or transportation to the appropriate service provider.[197]

The patient must be examined by a physician, clinical psychologist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist to determine if the patient meets the criteria for involuntary services within 72 hours of the initiation of the involuntary examination.[198] A patient may be released only upon the documented approval of a psychiatrist or clinical psychologist. If the receiving facility is owned or operated by a hospital, health system, or nationally accredited community health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist.

Involuntary Placement

If an individual continues to be in need of services, a treatment facility may petition the court to order either involuntary inpatient treatment or involuntary outpatient treatment for the individual.[199] Any petition for continued involuntary treatment, whether inpatient or outpatient, must be supported by the opinion of a psychiatrist, and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours and determined that the criteria for involuntary services are met.[200] In a hearing on such petitions, a court may issue an order for involuntary outpatient services, involuntary inpatient services, or an involuntary assessment, appoint a guardian, or order the patient's discharge.[201]

Voluntary Admissions

Baker Act receiving facilities may also admit any person 18 years of age or older making application by express and informed consent for admission, or any person age 17 or younger for whom such application is made by his or her guardian.[202] If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, a person 18 years of age or older may be admitted to the facility.[203] A person 17 years of age or younger may only be admitted after a clinical review to verify the voluntariness of the minor's assent.

Psychologists

The practice of psychology is the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.[204] Psychological services may be rendered to individuals, couples, families, groups, and the public without regard to place of service.

The Board of Psychology within DOH oversees the licensure and regulation of psychologists in Florida.[205] To be licensed as a psychologist the applicant must:

For licensure by examination:

- Hold a doctoral degree from a program accredited by the American Psychological Association;[206]

[197] Section 394.455(40), F.S.
[198] Section 394.463(2)(f)-(g), F.S.
[199] *See* ss. 394.4655 and 394.467, F.S.
[200] Sections 394.4655(3)-(4), F.S., for involuntary outpatient services, and ss. 394.467(2)-(4), F.S., for involuntary inpatient services.
[201] Section 394.4655(7), F.S., for involuntary outpatient services, and ss. 394.467(6), F.S., for involuntary inpatient services.
[202] Section 394.4625(1)(a), F.S.
[203] *Id*.
[204] Section 490.003(4), F.S.
[205] Section 490.004, F.S.

- Have at least two years or 4,000 hours of supervised experience in the field of psychology;
- Pass the Examination for Professional Practice in Psychology; and
- Pass an examination on Florida laws and rules.[207]

For licensure by endorsement:

- Be a diplomate in good standing with the American Board of Professional Psychology and pass an examination on Florida laws and rules; or
- Hold a doctoral degree in psychology and have at least 10 years' experience as a licensed psychologist in any U.S. jurisdiction within the preceding 25 years.[208]

Under current law, a "clinical psychologist" is a Florida-licensed psychologist with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the U.S. Department of Veterans Affairs that qualifies as a receiving or treatment facility.[209]

Psychiatric Nurses

Psychiatric nurses are licensed as advanced practice registered nurse who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.[210] The Board of Nursing within DOH oversees the licensure and regulation of advanced practice registered nurses. To obtain license as an advanced practice registered nurse in Florida, the nurse must submit an application and provide proof that he or she; [211]

- Holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing under the Nurse Licensure Compact;
- Is certified by the appropriate specialty board; and
- Has a master's degree in a clinical nursing specialty area with preparation in specialized practitioner skills.

For licensure as a psychiatric nurse, the applicant must hold one of the following certifications recognized by the Board of Nursing: [212]

- Psychiatric Mental Health Nurse Practitioner Certification;
- Family Psychiatric and Mental Health Nurse Practitioner;
- Adult Psychiatric and Mental Health Nurse Practitioner; or
- Psychiatric Adult Clinical Nurse Specialist (CNS).

In order to be recognized by the Board of Nursing, each specialty board must attest to the competency of nurses in the clinical specialty area, identify standards or scope of practice statements as appropriate

[206] Alternatively, the applicant may have received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology. The burden is on the applicant to establish that this requirement has been met.
[207] Section 490.005, F.S., and r. 64B19-11.001, F.A.C.
[208] Section 490.006, F.S.
[209] Section 394.455, F.S.
[210] Section 394.455, F.S.
[211] Section 464.012(1), F.S.
[212] Rule 64B9-4.002, F.A.C.

for the specialty, require a written examination for certification, and require completion of a formal program prior to eligibility of examination.[213]

Effect of the bill - Clinical Psychologists' and Psychiatric Nurses' Authority Under the Baker Act

Clinical Psychologists

The bill revises the definition of "clinical psychologist" to remove the three years of experience required under current law and authorizes a licensed clinical psychologist of any experience to:

- Perform an involuntary examination under the Baker Act;
- Provide a second opinion to support a recommendation that a patient receive involuntary outpatient services, if a psychiatrist or clinical psychologist with three years' experience is unavailable;
- Determine if the treatment plan for a patient is clinically appropriate; and
- Provide a second opinion to support a recommendation that a patient receive involuntary inpatient services if a psychiatrist or clinical psychologist with three years' experience is unavailable.

The bill retains a three-year clinical experience requirement for a clinical psychologist to:

- Authorize the transfer of a voluntary patient to an involuntary status;
- Authorize the discharge of a patient;
- Authorize the release of a patient after completion of an involuntary examination;
- Provide a second opinion to support a recommendation that a patient receive involuntary outpatient services;
- Provide a statement to the court in a proceeding justifying a request to continue involuntary outpatient services beyond the time ordered;
- Provide a second opinion to support a recommendation that a patient be involuntarily admitted for inpatient services; and
- Diagnose a child as psychotic or severely emotionally disturbed, if the clinical psychologist has specialty training and experience working with children.

Psychiatric Nurses

The bill revises the definition of "psychiatric nurse" to reduce the experience requirement from two years to one year and authorizes a psychiatric nurse with one year of experience to:

- Prohibit a patient from accessing clinical records if the psychiatric nurse determines such access would be harmful to the patient;
- Determine if the treatment plan for a patient is clinically appropriate;
- Authorize a person who is 14 years of age or older to be admitted to a bed in a room or ward in a mental health unit with an adult if the psychiatric nurse documents that such placement is medically indicated or for safety reasons; and
- Authorize the substitution of medications upon discharge of certain indigent patients if the psychiatric nurse determines such substitution is clinically indicated.

However, the bill requires a psychiatric nurse to be working within the framework of an established protocol with a psychiatrist to perform the following acts:

- Provide an opinion to a court on the competence of an individual to consent to treatment in a proceeding to appoint a guardian advocate;

[213] *Id.*

- For patients voluntarily admitted into a facility, document that a patient is able to give express and informed consent;
- Authorize emergency treatment of a patient if the psychiatric nurse determines that such treatment is necessary for the safety of the patient or others;
- Provide a second opinion to support a recommendation that a patient receive involuntary outpatient services;
- Provide that, in his or her clinical judgment, a patient has failed to comply with involuntary outpatient services and that efforts were made to effect compliance, and thus making the patient subject to an involuntary examination;
- Provide a second opinion to support a recommendation that a patient be involuntarily admitted for inpatient services; and
- Prescribe medications to a patient in a crisis stabilization unit.

Behavioral Health Acute Care System - Mobile Response Teams

DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. The behavioral health acute care system is a complex system that includes a variety of entities and integrated components that are essential for providing a public health safety net and comprehensive crisis response system for those with mental health and substance use disorders.

Crisis Response System

A crisis response system is a coordinated set of structures, processes and services put in place to respond to urgent and emerging mental health crisis. The system is designed to connect an individual experiencing a crisis to the appropriate level of care based on the assessed need of the individual. Key components of an effective crisis response system include regional or statewide crisis call centers coordinating in real time, centrally deployed 24/7 mobile crisis response teams, and readily available crisis receiving and stabilization programs.[214] Florida has various crisis support services that address the different components, including mobile response teams.

Mobile Response Teams

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him or her. It can be caused by a variety of factors and occur at any hour of the day.[215] Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals.[216] Law enforcement or EMTs may be called to respond to mental health crises, and may lack the training and experience to effectively handle the situation.[217] Mobile response teams (MRT) can be beneficial in such instances.

MRTs support the behavioral health crisis response system as these teams travel to the acute situation or crisis to provide assistance. MRTs provide on-demand, community-based crisis intervention services 24 hours a day, seven days per week, in any setting in which a behavioral health crisis is occurring.[218] Mobile response services are typically provided by a team of crisis-intervention trained professionals

[214] Substance Abuse and Mental Health Services (SAMHSA), *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*, available at https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf, (last visited January 8, 2024)
[215] Department of Children and Families, *Mobile Response Teams Framework*, (August 29, 2018), p. 4 https://myflfamilies.com/sites/default/files/2022-12/Mobile%20Response%20Framework.pdf (last visited January 8, 2024).
[216] *Id.*
[217] *Id.*
[218] *Id.*

and paraprofessionals who use face-to-face professional and peer intervention. MRTs are deployed in real time to the location of the person in crisis in order to achieve the best outcomes necessary for that individual, ensuring timely access to assessment, evaluation, support, and other services.[219] MRTs provide a warm handoff to other services, coordinate care, and ensure that the individual is engaged in services. MRTs are required to remained engaged for a minimum of 72 hours to ensure that the individual is actively connected to another service provider.[220]

In 1996, the Legislature integrated mobile crisis response services into Part I of ch. 394, F.S., the Florida Mental Health Act and authorized DCF to adopt rules establishing the minimum standards for services provided and for the personnel employed by a mobile crisis response service.[221] Under Part 1 of ch. 394, F.S., mobile crisis response services, such as MRTs, are contracted through DCF and provide general onsite behavioral health crisis services to persons of all ages in various capacities throughout the state.

DCF rules lists the minimum standards that authorized mobile crisis response service providers must adhere to.[222] The minimum standards list broad requirements and serve as a guideline for providers to use when establishing policy and procedures for operation of mobile crisis response services. Authorized service providers are required to establish and enforce a DCF-approved policy and procedures manual for the specific service being provided. The manual must be consistent with the provisions of Part I of ch. 394, F.S., and include processes and procedures to address the minimum standards specified in rule.[223] A few of the standards that must be included in the manual are:[224]

- A description of the services offered, eligibility criteria, how eligible recipients are informed of service availability, criteria for response, hours of operation, staffing with staff qualifications and supervision, and organizational line of authority to the operating entity;
- Procedures for mechanisms to monitor and evaluate service quality and the outcomes attained by individuals served;
- Procedures to determine whether the individual being served has a case manager from a mental health center or clinic, and procedures requiring notification and coordination of activities with the case manager;
- Procedures to implement voluntary admissions provisions; and
- Procedures for transporting individuals subject to involuntary examination.

In 2020, the Legislature required crisis response services be provided through MRTs under Part III of ch. 394, F.S., (Comprehensive Child and Adolescent Mental Health Services).[225] This requires DCF to contract with the managing entities[226] to procure mobile response teams throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18-25, inclusive, who:[227]

- Have an emotional disturbance;
- Are experiencing an acute mental or emotional crisis;

[219] *Id*.
[220] DCF correspondence to House Children, Families, & Seniors Subcommittee staff (Email dated December 4, 2023, on file with House Children, Families, & Seniors Subcommittee).
[221] Chapter 1996-169, Laws of Florida and s. 394.457, F.S.
[222] Rule 65E-5.400(6), F.A.C.
[223] *Id*.
[224] *Id*.
[225] See Chapter 2020-107, L.O.F.
[226] DCF contracts for behavioral health services through regional systems of care called Managing Entities (MEs). These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state. Currently, the DCF contracts with seven MEs. *See* Department of Children and Families, *Managing Entities, available at* https://www.myflfamilies.com/services/_samh/providers/managing-entities (last visited January 8, 2024).
[227] S. 394.495(7)(a), F.S.

- Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function normally within their environment; or
- Are served by the child welfare system and are experiencing or are at high risk of placement instability.

Part III of ch. 394, F.S., lists specific and detailed requirements for MRTs. Under Part III of ch. 394, F.S., MRTs are required to:

- Triage new requests to determine the level of severity and prioritize new requests that meet the clinical threshold for an in-person response and provide in-person responses to such calls meeting the clinical level of response within 60 minutes after prioritization;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family;
- Provide evidence-based practices to children, adolescents, young adults, and families to enable them to de-escalate and respond to behavioral challenges that they are facing and to reduce the potential for future crises;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure there is a process in place for informed consent and confidentiality compliance measures;
- Promote information sharing and the use of innovative technology; and
- Coordinate with the applicable managing entity to establish informal partnerships with key entities providing behavioral health services and supports to children, adolescents, or young adults and their families to facilitate continuity of care.

In Fiscal Year (FY) 2022-23, DCF received additional funding for MRTs under Part III of ch. 394, F.S., allowing for the implementation of 12 new MRTs and the expansion of 30 existing children's teams. Currently there are 51 MRTs serving all 67 counties in Florida.[228] During FY 2022-23, the MRTs received a total of 28,294 calls and served 22,435 individuals.[229] A recent review of MRT data from 2019 through 2022 shows that approximately 82 percent of MRT engagements resulted in community stabilization rather than involuntary admission or deeper penetration into the behavioral health system.[230]

Effect of the bill - Behavioral Health Acute Care System - Mobile Response Teams

The bill requires the minimum standards for the general mobile crisis response services under Part I of ch. 394, F.S., to include the mobile crisis response service and MRT standards established under Part III of ch. 394, F.S., for children, adolescents, and young adults. The bill also requires the minimum standards for general MRTs under Part 1 of ch. 394, F.S., to ensure coverage for adults over age 25 in all counties and to focus on rapid crisis intervention, emergency room diversion, the provision of and referral to services that are responsive to the needs of the individuals in crisis and his or her family. Further the bill implements follow-up procedures requiring MRTs to follow-up with the individual at 90

[228] DCF, Agency *Legislative Budget Request for Fiscal Year 2024-2025*, available at http://floridafiscalportal.state.fl.us/Document.aspx?ID=26122&DocType=PDF , (last visited January 8, 2024).
[229] DCF correspondence to House Children, Families, & Seniors Subcommittee staff (Email dated December 4, 2023, on file with House Children, Families, & Seniors Subcommittee).
[230] Department of Children and Families, *Triennial Plan for the Delivery of Mental Health and Substance Abuse Services: State Fiscal Years 2023-2024 and 2025-2026, pg. 6, available at* https://www.google.com/url?client=internal-element-cse&cx=b5f7422ffe5734ed7&q=https://www.my flfamilies.com/sites/default/files/2023-06/Substance%2520Abuse%2520%2526%2520Mental%2520Health%2520Services%2520Triennial%2520State%2520and%2520Regional%2520Master%2520Plan%2520%25202023-2025.pdf (last visited Nov. 28, 2023).

and 180 days to gather outcome data on the mobile crisis response encounter to determine the effectiveness of the mobile crisis response services that were provided.

While the mobile crisis response service and MRT provisions under Parts I and III of ch. 394, are not in conflict, the bill aligns the requirements and performance expectations between the two types of MRTs, while preserving the focus of MRTs serving children, adolescents, and young adults under Part III of ch. 394. The alignment of these standards will require changes to existing DCF rules to include the MRT standards under Part III of ch. 394, F.S., and implement the additional MRT minimum standard provisions of the bill.

The terms “mobile crisis response service” and mobile response teams” are used interchangeably throughout Parts I and III. The bill amends s. 394.455, F.S. to make it clear that the terms “mobile crisis response service” and “mobile response team” have the same meaning.

Graduate Medical Education

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.[231] Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.[232]

Every U.S. state requires at least one year of residency training to receive an unrestricted license to practice medicine, and some require two or three years. However, most physicians train beyond the minimum licensure requirement in order to become board certified in a “pipeline” specialty (i.e., those that lead to initial board certification). The number of pipeline training positions determines the total number of physicians that the entire continuum can produce. For many years, the number of U.S. residency slots has been larger than the number of U.S. medical graduates, so residency programs were filled in part by graduates of non-U.S. medical schools (including both U.S. and non-U.S. citizens). Now, with growth in the number and size of medical schools, the number of U.S. medical graduates is beginning to more closely approximate the current number of residency slots. In a recent survey conducted by the Association of American Medical Colleges (AAMC), 122 of 130 responding medical school deans reported some concern about the number of post-graduate training opportunities for their students.[233]

Medicare Funding of GME

GME is largely funded through both the Medicare and the Medicaid programs. Until the enactment of the Balanced Budget Act (BBA) of 1997, Medicare support of GME was open-ended. Before the BBA, hospitals had a strong financial incentive to add new residency slots because each new position generated additional Medicare per-resident amount and indirect medical education revenues. In response to concerns about an oversupply of physicians and increasing Medicare costs, the BBA capped the number of Medicare-supported physician training slots.[234]

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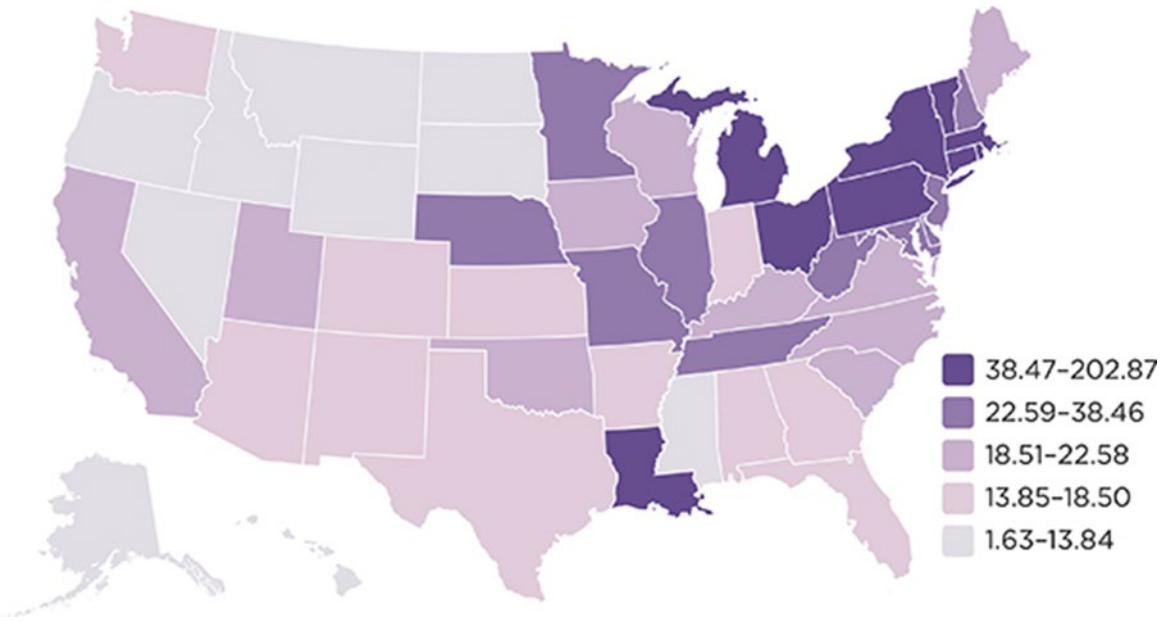
[231] *Graduate Medical Education That Meets the Nation's Health Needs*, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited January 8, 2024).
[232] *Id.*
[233] *Id.*
[234] *Id.*

Hospitals are free to add residents beyond their cap, but these trainees do not generate additional Medicare revenues. The cap on Medicare funding was set at each hospital's resident count in the cost report period ending on or before December 31, 1996. With this step, the geographic distribution of Medicare-supported residencies was essentially frozen in place without regard for future changes in local or regional health workforce priorities or the geography or demography of the U.S. population. As can be seen by the following chart (showing the number of Medicare-funded training positions per 100,000 population), Medicare-supported slots are most highly concentrated in the Northeastern states, as is most of Medicare GME funding.[235]



Medicaid Funding of GME

GME is an approved component of Medicaid inpatient and outpatient hospital services.[236] If a state Medicaid program opts to cover GME costs, the federal government provides matching funds.[237] Florida opts to fund GME through the Statewide Medicaid Residency Program (SMRP).[238] For fiscal year 2023-2024, the SMRP funded 6,176 residents at 83 location.[239]

The SMRP allows both hospitals and FQHCs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME) to qualify for GME funding. In addition to the SMRP, the Legislature has allocated additional funding to GME through the Startup Bonus Program and the Slots for Doctors Program.

Startup Bonus Program (SBP)[240]

The SBP was established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit. The program allocates a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty in statewide supply-and-demand

[235] *Id.*
[236] *Id.*
[237] *Id.*
[238] Section 409.909, F.S.
[239] SFY 2023-24 Statewide Medicaid Residency Program Distribution, AHCA, available at https://ahca.myflorida.com/content/download/23217/file/SFY%2023-24%20GME%20SMRP%20Calculation%20Clean.pdf, (last visited January 8, 2024).
[240] Section 409.909(5), F.S.

deficit. For the purposes of the program, physician specialties in statewide supply-and-demand deficit are identified in the General Appropriations Act (GAA).[241]

The Slots for Doctors Program (SDP)

The SDP requires the AHCA to annually allocate $100,000 to hospitals and qualifying institutions for each newly created slot that is first filled on or after June 1, 2023, and remains filled thereafter.[242] The new slot must be accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit. The sections specify that the program is designed to generate matching funds under the Medicaid program and distribute those funds to participating hospitals and qualifying institutions and that specialties and sub-specialties are those that are identified in the GAA.

Specialties and Sub-Specialties in Supply and Demand Deficit

The 2023-24 GAA lists the following specialties and subspecialties as being in supply-and-demand deficit:

- Allergy or immunology;
- Anesthesiology;
- Cardiology;
- Colon and rectal surgery;
- Emergency medicine;
- Endocrinology;
- Family medicine;
- Gastroenterology;
- General internal medicine;
- Geriatric medicine;
- Hematology;
- Oncology;
- Infectious diseases;
- Neonatology;
- Nephrology;
- Neurological surgery;
- Obstetrics/gynecology;
- Ophthalmology;
- Orthopedic surgery;
- Pediatrics;
- Physical medicine and rehabilitation;
- Plastic surgery/reconstructive surgery;
- Psychiatry;
- Pulmonary/critical care;
- Radiation oncology;
- Rheumatology;
- Thoracic surgery;
- Urology; and
- Vascular surgery.

[241] Chapter 2023-239, Laws of Florida
[242] Section 409.909(6), F.S.

Ohio's Primary Care Workforce Initiatives (OPCWI)

The goal of the OPCWI is to expose health professional students to patient centered medical homes (PCMHs) and provide a standardized, high-quality educational experience while providing support for the administrative costs and decrease in revenue typically associated with hosting and training students. To accomplish this, the OPCWI provides training and technical support for preceptors and compensates participating health centers such as FQHCs, not preceptors, for the time their staff spend teaching students.

Health centers may host students in the following disciplines: medicine, dentistry, advanced practice nursing, physician assisting, and behavioral health. These structured clinical experiences are designed to increase primary care capacity in some of the most underserved neighborhoods in Ohio. Located throughout the state, Ohio's FQHCs serve over 850,000 Ohioans each year. Participating health centers have, or commit to obtaining, national recognition as PCMHs so that students can experience an advanced primary care practice model.[243]

The OPCWI pays quarterly at an hourly rate determined by the type of provider:[244]

1st Year Med. Student	$27/hr.
2nd Year	$27/hr.
3rd Year	$29/hr.
4th Year	$29/hr.
Dentist	$22/hr.
APRN	$22/hr.
PA	$22/hr.
Behavioral Health	$15/hr.

Effect of the bill - Graduate Medical Education

The bill amends SDP to allow the AHCA to fund up to 200 residency slots that were in existence prior to July 1, 2023, as long as those slots:

- Are in a physician specialty or subspecialty experiencing a statewide supply-and-demand deficit;
- Have been unfilled for a period of 3 or more years;
- Are subsequently filled on or after June 1, 2024, and remain filled thereafter; and
- Are accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program.

Additionally, the bill specifies that if there are more applicants for the SDP than there is available funding or number of authorized slots, the AHCA must prioritize positions that are in primary care, as specified in paragraph (2)(a).

Reporting Requirements

The bill amends s. 409.909, F.S., to require any hospital or qualifying institution[245] that receives state funds under the SMRP, including, but not limited to intergovernmental transfers, to annually report data to the AHCA.

[243] Y8 Ohio Primary Care Workforce Initiative (OPCWI) User Manual, Ohio Association of Community Health Centers, available at Y8_OPCWI_User_Manual.pdf (ymaws.com), (last visited January 8, 2024).
[244] *Id.* at p. 6.
[245] A qualifying institution is defined in s. 409.909, F.S., as a federally Qualified Health Center holding an Accreditation Council for Graduate Medical Education institutional accreditation.

Specific to funds allocated other than from the Startup Bonus Program, the bill requires the data to include, at a minimum:

- The sponsoring institution for the resident position. As used in this section, the term "sponsoring institution" means an organization that oversees, supports, and administers one or more resident positions.
- The year the position was created and the current program year of the resident who is filling the position.
- Whether the position is currently filled and whether there has been any period of time when it was not filled.
- The specialty or subspecialty for which the position is accredited and whether the position is a fellowship position.
- Each state funding source that was used to create the position or is being used to maintain the position, and the general purpose for which the funds were used.

If the funds were allocated under the Startup Bonus Program on or after July 1, 2021, the data must include:

- The date on which the hospital or qualifying institution applied for funds under the program.
- The date on which the position funded by the program became accredited.
- The date on which the position was first filled and whether it has remained filled.
- The specialty of the position created.

Additionally, beginning July 1, 2025, each hospital a or qualifying institution is required to annually produce detailed financial records no later than 30 days after the end of its fiscal year that detail the manner in which state funds were allocated under the SMRP were expended. The bill exempts funds that were allocated before July 1, 2025. The AHCA is also authorized to require that any hospital or qualifying institution submit to an audit of its financial records related to funds allocated under the SMRP after July 1, 2025.

If a hospital or qualifying institution fails to produce any of the required information or records, the hospital or qualifying institution is no longer eligible to participate in any Medicaid GME program until the AHCA has determined it has produced the records.

Residency Exit Survey

The bill requires that each qualifying institution and hospital must request an exiting resident to fill out an exit survey on a form developed by the AHCA. The surveys must be provided annually to the AHCA and must include, at a minimum, questions on:

- Whether the exiting resident has procured employment.
- Whether the exiting resident plans to leave the state and, if so, for which reasons.
- Where and in which specialty the exiting resident intends to practice.
- Whether the exiting resident envisions himself or herself working in the medical field as a long-term career.

Graduate Medical Education Committee (GMEC)

The bill establishes the GMEC within the AHCA. The committee will be made up of:

- Three deans, or their designees, from medical schools in this state, appointed by the chair of the Council of Florida Medical School Deans.
- Four members appointed by the Governor, one of whom is a representative of the Florida Medical Association or the Florida Osteopathic Medical Association who has supervised or is currently supervising residents, one of whom is a member of the Florida Hospital Association,

one of whom is a member of the Safety Net Hospital Alliance, and one of whom is a physician licensed under ch. 458 or ch. 459, F.S., practicing at a qualifying institution.
- Two members appointed by the Secretary of Health Care Administration, one of whom represents a teaching hospital as defined in s. 408.07, F.S., and one of whom is a physician who has supervised or is currently supervising residents.
- Two members appointed by the State Surgeon General, one of whom must represent a teaching hospital as defined in s. 408.07, F.S., and one of whom is a physician who has supervised or is currently supervising residents or interns.
- Two members, one appointed by the President of the Senate and one appointed by the Speaker of the House of the Representatives.

The bill specifies that the members who are medical school deans will serve four-year terms and rotate membership through the medical schools in Florida. Otherwise, members serve four-year terms with the initial terms being three or two years for specified members in order to stagger changes of membership. The GMEC must elect a chair to serve for a one-year term and members are required to serve without compensation but are entitled to reimbursement for per diem.

The bill requires the committee to convene its first meeting by July 1, 2024, and to meet at least twice annually at the call of the chair. Meetings may be conducted electronically with a majority of the members representing a quorum.

Beginning July 1, 2025, the committee is required to submit an annual report to the Governor and the Legislature detailing:

- The role of residents and medical faculty in the provision of health care.
- The relationship of graduate medical education to the state's physician workforce.
- The typical workload for residents and the role such workload plays in retaining physicians in the long-term workforce.
- The costs of training medical residents for hospitals and qualifying institutions.
- The availability and adequacy of all sources of revenue available to support graduate medical education.
- The use of state funds, including, but not limited to, intergovernmental transfers, for graduate medical education for each hospital or qualifying institution receiving such funds.

The bill requires the AHCA to provide reasonable and necessary support staff and materials to the committee, to provide the information obtained from the reporting requirements created by the bill, and to assist the committee in obtaining any other information necessary to produce its report.

Training, Education, and Clinicals in Health (TEACH) Funding Program

The bill creates s. 409.91256, F.S., to establish the TEACH Funding Program. The program is created to provide a high-quality educational experience while supporting participating federally qualified health centers, community mental health centers, rural health clinics, and certified community behavioral health clinics by offsetting administrative costs and loss of revenue associated with training residents and students to become licensed health care practitioners. The bill provides legislative intent that the program be used to support the state Medicaid program and underserved populations by expanding the available health care workforce.

The bill defines the following terms:

- "Preceptor" to mean a Florida-licensed health care practitioner who directs, teaches, supervises, and evaluates the learning experience of a resident or student during a clinical rotation.

- “Primary care specialty” to mean general internal medicine, family medicine, obstetrics and gynecology, general pediatrics, psychiatry, geriatric medicine, or any other specialty the agency identifies as primary care.
- “Qualified facility” to mean an FQHC, community mental health center, rural health clinic, or certified community behavioral health clinic.

The bill requires the AHCA to develop an application process for qualified facilities to apply for funds to offset administrative costs and loss of revenue associated with establishing, maintaining, or expanding a clinical training program.

Once an application is approved, the AHCA is required to enter into an agreement with the qualified facility that requires the facility to, at a minimum:

- Agree to provide appropriate supervision or precepting for one or more of:
- Allopathic or osteopathic residents pursuing a primary care specialty.
- Advanced practice registered nursing students pursuing a primary care specialty.
- Nursing students.
- Allopathic or osteopathic medical students.
- Dental students.
- Physician assistant students.
- Behavioral health students, including students studying psychology, clinical social work, marriage and family therapy, or mental health counseling.
- Meet and maintain all requirements to operate on accredited residency program if the qualified facility operates a residency program.
- Obtain and maintain accreditation from an accreditation body approved by the AHCA if the qualified facility provides clinical rotations.
- Ensure that clinical preceptors meet AHCA standards for precepting students, including any required training.
- Provide preference for residents and students enrolled in Florida schools or whose state of legal residence is Florida.
- Submit quarterly reports to the AHCA by the first day of the second month following each quarter which must, at a minimum, include:
- The type of residency or clinical rotation offered by the qualified facility, the number of residents or students participating in each type of clinical rotation or residency, and the number of hours worked by each resident or student each month.
- Evaluations by the residents and student participants of the clinical experience on an evaluation form developed by the agency.
- An itemized list of administrative costs associated with the operation of the clinical training program, including accreditation costs and other costs relating to the creation, implementation, and maintenance of the program.
- A calculation of lost revenue associated with operating the clinical training program.

The bill requires the AHCA, in consultation with the DOH to develop, or contract for, training for preceptors and make such training available in either a live or electronic format. The AHCA is also required to provide technical support for preceptors.

Qualified facilities may be reimbursed to offset the administrative costs or lost revenue associated with training students and residents who are enrolled in an accredited educational or residency program in Florida. Subject to appropriation, the AHCA may reimburse a qualified facility based on the number of clinical training hours reported at the following rates:

- A medical resident at a rate of $50 per hour.
- A first-year medical student at a rate of $27 per hour.
- A second-year medical student at a rate of $27 per hour.
- A third-year medical student at a rate of $29 per hour.

- A fourth-year medical student at a rate of $29 per hour.
- A dental student at a rate of $22 per hour.
- An APRN student at a rate of $22 per hour.
- A PA student at a rate of $22 per hour.
- A behavioral health student at a rate of $15 per hour.

A qualified facility may not be reimbursed more than $75,000 per fiscal year or $100,000 if the facility operates a residency program.

A qualified facility that receives payments under the program must provide information to the AHCA for the purpose of the AHCA's reporting requirements in the bill. The AHCA is required to submit an annual report to the Governor and the Legislature, with the first report due by December 1, 2025, detailing, at a minimum:

- The number of students trained in the program, by school, area of study, and clinical hours earned.
- The number of students trained and the amount of program funds received by each participating federally qualified health center or certified community behavioral health clinic.
- The number of program participants found to be employed by a federally qualified health center or a certified community behavioral health clinic or in a federally designated health professional shortage area upon completion of their education and training.
- Any other data the agency deems useful for determining the effectiveness of the program.

The bill also requires the AHCA to contract with an independent third party to develop and conduct a study to evaluate the impact of the TEACH program, including, but not limited to the program's effectiveness in enabling qualified facilities to provide opportunities for clinical rotations and residencies and enabling the recruitment and retention of health care professionals in geographic and practice areas that have experienced shortages. The bill requires the AHCA to begin collecting data by January 1, 2025, and submit the study to the Governor and the Legislature by January 1, 2030.

The AHCA is authorized to adopt rules to implement the program and is required to seek federal approval to use Title XIX matching funds for the program.

The program sunsets on July 1, 2034, under the bill.

Offshore Usage of Clinical Training Opportunities

One problem facing Florida medical schools seeking to increase their student body is a lack of availability of clinical training opportunities. According to a new AAMC (Association of American Medical Colleges) report, 84 percent of medical school deans were concerned about the number of clinical training sites for medical school students even before the COVID-19 pandemic.

More than 70 percent of surveyed deans worried about having enough qualified specialty preceptors, and the response jumped to 87 percent for primary care preceptors. One reason for this is an increase in competition for clinical training opportunities from offshore medical schools. Such offshore medical schools may not be able to offer core clinical experiences where they are located. Instead they rely on training sites within the United States. In order to secure these sites, offshore medical schools will often pay the clinical locations such as hospitals in order to place their students there. Although most U.S. medical schools do not pay hospitals or other settings for clinical training, the AAMC survey of deans found that 44 percent of respondents felt moderate to severe pressure to do so.[246]

Effect of the bill - Offshore Usage of Clinical Training Opportunities

[246] *So Many Medical Students, so Few Clerkship Sites*, AAMCNEWS, Sep. 10, 2020, available at https://www.aamc.org/news/so-many-medical-students-so-few-clerkship-sites#:~:text=According%20to%20a%20new%20AAMC,sites%20even%20before%20the%20pandemic., (last visited January 8, 2024).

The bill amends s. 395.1055, F.S., to prohibit a hospital from accepting any payment from a medical school directly, or indirectly, related to allowing students from the medical school to obtain clinical hours or instruction at the hospital.

The Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[247] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[248]

Medicaid Provider Enrollment

Federal exceptions excluded, to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time the service is rendered. Practices must be fully operational before they can be enrolled as Medicaid providers. Every entity that provides Medicaid services to enrollees and all third-party software vendors offering services of any kind to providers must enroll as a Medicaid provider.[249]

The AHCA and its fiscal agent, Gainwell Technologies, develop comprehensive education materials, including reference guides, to assist applicants with the enrollment process, as well as answer the questions of any providers interested in Medicaid enrollment, published on their respective websites.[250]

Statewide Medicaid Managed Care

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. In Florida, the majority of Medicaid enrollees receive their services through a managed care plan contracted with the AHCA under SMMC.[251]

SMMC has three components: MMA, Long-Term Care (LTC), and Dental. Florida's SMMC benefits are authorized through federal waivers and are specifically required by the Florida Legislature in s. 409.973, F.S., and s. 409.98, F.S.[252] MMA plans provide preventive, acute, behavioral, therapeutic pharmacy, and transportation services to eligible recipients.[253]

Qualifying Community-Based Mobile Crisis Intervention Services

Section 9813 of the federal American Rescue Plan Act of 2021 (ARPA) amended Title XIX of the Social Security Act (Act) to add a new section 1947, authorizing states to provide qualifying community-based

[247] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited January 8, 2024).
[248] Section 20.42, F.S.
[249] Florida Agency for Health Care Administration & Gainwell Technologies, *Florida Medicaid Provider Enrollment Application Guide, available at* https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Public%20Misc%20Files/Florida%20Medicaid%20Provider%20Enrollment%20App%20Guide.pdf (last visited January 8, 2024).
[250] *Id*.
[251] Section 20.42, F.S.
[252] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited January 8, 2024).
[253] Florida Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program, available at* https://ahca.myflorida.com/content/download/9126/file/SMMC_Snapshot.pdf (last visited January 8, 2024).

mobile crisis intervention services during the period beginning April 1, 2022, and ending March 31, 2027. States with approved coverage and reimbursement authority can receive 85 percent federal match for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period during which they meet the federally outlined conditions. States are permitted to disregard the provider agreement requirements at s. 1902(a)(27) of the Act that obligate states to enter into provider agreements with "every person or institution providing services under the State plan."[254]

The Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration both describe mobile crisis services as readily available 24 hours a day, and seven days a week services that can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call to respond. The team may be composed of professionals and paraprofessionals, including trained peer support providers, who are educated in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis.[255]

Primary Care Initiative Program

At present, plans operating in the MMA component of SMMC must establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan is required to:[256]

- Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider;
- Assist new Medicaid enrollees in scheduling an appointment with a primary care provider within 30 days after enrollment in the plan, if possible;
- Report to the AHCA the number of enrollees assigned to each primary care provider within the plan's network;
- Report to the AHCA the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment; and
- Report to the AHCA the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Medicaid Encounter Data System

Currently, the AHCA operates a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in a managed care plan. Each plan must comply with the AHCA's reporting requirements for the Medicaid Encounter Data System, submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act (HIPAA) provisions for electronic claims, and submit encounter data in accordance with deadlines established by the AHCA. The managed care plans must certify the reported data is accurate and complete.[257]

The AHCA is responsible for validating the data submitted by the plans and has developed methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of SMMC enrollees to allow comparison of service utilization among plans and against expected levels of use. Presently, the analysis is used to identify possible cases of inappropriate service utilization, such

[254] *Centers for Medicare & Medicaid Services, SHO # 21-008: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, available at* https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf (last visited January 8, 2024).
[255] *Id*.
[256] Section 409.973(4), F.S.
[257] Section 409.967(2)(e), F.S.

as higher-than-expected emergency department encounters[258] or PPEs, to improve access to quality health care services while also reducing expenditures.[259]

Florida's Health Information Exchange Program

Founded in 2011, the Florida Health Information Exchange (FHIE) facilitates the secure statewide exchange of health information between health care providers, hospital systems, and payers. The AHCA governs the FHIE by establishing policy, convening stakeholders, providing oversight, engaging federal partners, and promoting the benefits of health information technology.

The FHIE electronically makes patient health information available to doctors, nurses, hospitals, and health care organizations when needed for patient care. The exchange of patient information is protected through strict medical privacy and confidential procedures. The FHIE is designed to improve the speed, quality, safety, and cost of patient care.[260]

As part of the AHCA's FHIE Services, Florida has developed an Encounter Notification Service (ENS) that delivers real-time notifications based off of Admit, Discharge, and Transfer (ADT) data from participating health care facilities. This data is provided to authorize health care entities to improve patient care coordination. Over 8 million monthly alerts are being sent and more than 700 data sources are presently using ENS, including:

- 95 percent of Licensed Acute Care Hospitals
- 225 Skilled Nursing Facilities
- 64 Urgent Care Centers
- 22 Hospice Providers
- 5 Crisis Stabilization Units
- Statewide Emergency Medical Services Treat-and-Release Providers
- All 67 County Health Departments.[261]

Hospitals that receive Low Income Pool funding are required to participate in the FHIE's Encounter Notification Service, and Medicaid Managed Care Plans also participate as part of their contractual agreements. To participate as subscribers of the ENS service, the AHCA has a standard rate per organization type. The lowest fees are $500 per year for less than 5,000 subscribed patients. Other payment structures vary with the highest minimum annual fee not exceeding $7,500.

FHIE services support public health activities, including real-time reporting of inpatient hospital stays for syndromic surveillance, data sharing with county health departments, emergency medical services, and identified health care registries.

Although data sharing has grown and improved over time, there are several providers not sharing complete data sets due to various reasons such as workflow issues or turnover of staff that is familiar with FHIE needs. The incomplete data limits the ability for subscribers of ENS to have a complete picture of patient care. The incomplete data negatively impacts the AHCA's public health partners who are receiving data through the Florida HIE Services.[262]

Effect of the bill - Florida's Health Information Exchange Program

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[258] *Id.*
[259] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).
[260] AHCA analysis document, on file with Senate Health Policy Committee staff.
[261] *Id.*
[262] *Id.*

The bill requires each hospital that maintains a certified electronic health record technology to make available its admit, transfer, and discharge data to the FHIE program for the purpose of supporting public health data registries and patient care coordination. The bill authorizes the AHCA to adopt rules to implement this provision.

Emergency Department (ED) Diversion

Emergency Department Diversion

Hospitals are licensed and regulated by the Agency for Health Care Administration (AHCA) under part I of ch. 395, F.S. In Florida, emergency departments (EDs) are either located in a hospital or on separate premises of a licensed hospital. Any licensed hospital which has a dedicated ED may provide emergency services in a location separate from the hospital's main premises, known as a hospital-based off-campus emergency department.[263] 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.[264]

Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition.[265] CMS can issue civil monetary penalties to hospitals and physicians for each violation of this provision and can exclude a physician from participation in any federal health care program.[266] The penalty amounts are adjusted annually for inflation. Penalty amounts for the 2023 calendar year are as follows:

- $129,232 for a hospital or responsible physician in a hospital with more than 100 beds; and
- $64,618 for a hospital or responsible physician in a hospital with fewer than 100 beds.[267]

Pursuant to CMS guidance on EMTALA regulations, hospitals should not delay providing a medical screening examination or necessary stabilizing treatment by inquiring about an individual's ability to pay for care.[268] However, hospitals may follow reasonable registration processes for individuals presenting with an emergency medical condition. Reasonable registration processes may include asking whether an individual is insured and, if so, what the insurance is, as long as the inquiry does not delay screening, treatment or unduly discourage the individual from remaining for further evaluation.

Avoidable emergency department visits put a significant strain on the health care system by increasing overall costs and leading to ED overcrowding.[269] A large proportion of all ED visits in the U.S. are for non-urgent conditions,[270] potentially as high as 37 percent.[271] A study estimated that annual savings of $4.4 billion could be achieved if non-urgent ED visits were cared for in retail clinics or urgent care

[263] Section 395.002(13), F.S.
[264] Section 395.1041, F.S.
[265] 42 U.S.C. §1395dd and 42 C.F.R, § 489.24.
[266] 42 C.F.R., § 1003.510
[267] 42 C.F.R., § 102.3
[268] CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Interpretive Guidelines for §489.24(d)(4)(i),(ii),(iii) and (iv), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf (last visited January 8, 2024).
[269] Uscher-Pines L, Pines J, Kellermann A, Gillen E, Mehrotra A. Emergency department visits for nonurgent conditions: systematic literature review. Am J Manag Care. 2013 Jan;19(1):47-59. PMID: 23379744; PMCID: PMC4156292.
[270] Non-urgent conditions are typically defined as conditions for which a delay in treatment of several hours would not increase the likelihood of an adverse outcome.
[271] *Supra*, note 273.

centers.[272] Some of the known drivers attributed to ED overuse are indigent populations, such as Medicaid enrollees, as well as others who may lack health insurance and access to timely and quality care, leaving hospitals with the financial and legal obligation to stabilize all patients who arrive in the ED.[273]

Florida has attempted to address the problem of inappropriate ED use in the past.[274] For example, the insurance code requires insurers and health maintenance organizations (HMOs) to have ED diversion programs and provide information to consumers about alternatives to the ED, and authorizes them to charge higher copayments for primary care services in an ED.[275] Similarly, current law authorizes hospitals to develop ED diversion programs, but does not require them to do so. Such programs can include a hotline to help patients determine where to seek treatment, and a "fast track" program allowing nonemergency patients to seek treatment at a different location.[276]

Urgent Care Centers

An urgent care center is a facility or clinic that provides immediate but not emergent ambulatory medical care to patients.[277] There is no licensure program specifically for urgent care centers. A hospital-owned urgent care center can operate under the license of the hospital. A physician-owned urgent care center is required to be licensed as a health care clinic, unless it meets one of the exemptions contained in s. 400.9905, F.S.

Federally Qualified Health Centers

A Federally Qualified Health Center (FQHC), also known as a community health center, is a federally funded safety net provider that provides primary and preventive health services.[278] FQHCs integrate access to primary care, pharmacy, mental health, substance use disorder, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care.[279] There are 776 FQHCs in Florida.[280]

Effect of the bill - Emergency Department (ED) Diversion

The bill requires all hospitals with EDs, including hospital-based off-campus EDs, to submit a diversion plan to AHCA for assisting patients with gaining access to appropriate care settings when such patient presents at the ED with non-emergent health care needs or indicate when receiving triage or treatment at the hospital that they lack regular access to primary care. Starting July 1, 2025, the plan must be approved by AHCA prior to first licensure or licensure renewal. The bill requires all hospitals to submit data to AHCA demonstrating the effectiveness of its ED diversion plan annually and update the plan as necessary, or as directed by AHCA, prior to licensure renewal.

The ED diversion plan must include at least one of the following:

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[272] Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. Health Aff (Millwood). 2010 Sep;29(9):1630-6. doi: 10.1377/hlthaff.2009.0748. PMID: 20820018; PMCID: PMC3412873.
[273] The Journal of Urgent Care Medicine, *Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program, available at* https://www.jucm.com/reducing-low-acuity-preventable-emergency-room-visits-by-utilizing-urgent-care-center-services-via-mobile-health-unit-diversion-program/ (last visited January 8, 2024).
[274] The Legislature specifically found that the costs of inappropriate utilization of ED services are ultimately borne by the hospital, the insured patients, and state taxpayers, and declared that providers and insurers must share the responsibility of providing alternative treatment options to urgent care patients through consumer education and implementation of mechanisms result in a decrease in ED overutilization. S. 641.31097, F.S.
[275] Sections 627.6405, 641.31097, F.S.
[276] Section 395.1041(7), F.S.
[277] Section 395.002(30), F.S.
[278] 42 U.S.C. §254b.
[279] U.S. Health Resources & Services Administration, *What is a Health Center?*, available at https://bphc.hrsa.gov/about-health-centers/what-health-center (last visited January 8, 2024).
[280] U.S. Health Resources & Services Administration, *FQHCs and LALs by State*, available at https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs (last visited January 8, 2024).

- A partnership agreement with one or more nearby federally qualified health centers (FQHCs) or other primary care settings. The goal of the agreement must include, but need not be limited to:
    - Identifying patients who present at the ED for non-emergent care, care that would best be provided in a primary care setting, or emergency care that could potentially have been avoided through the regular provision of primary care; and
    - Establishing a relationship between the patient and the FQHC or other primary care setting so that the patient develops a medical home at such setting for non-emergent and preventative health care services.
- The establishment, construction, and operation of a hospital-owned urgent care center adjacent to the hospital ED or an agreement with an urgent care center located within three miles in an urban area or 10 miles in a rural area. The hospital must seek to divert to the urgent care center those patients who present at the ED needing non-emergent health care services and subsequently help those patients obtain primary care.

Additionally, the bill requires the ED diversion plan to include outreach to a patient's managed care plan and coordination with the plan to establish a relationship between the patient and a primary care setting. The bill requires AHCA to establish a process for the hospital to share the patient's updated contact information with the managed care plan.

Potentially Preventable Health Care Events (PPEs)

PPEs are encounters that could be prevented but lead to unnecessary health care services.[281]

Potentially Preventable Hospital Emergency Department Visits

Potentially preventable hospital emergency department visits happen when a patient seeks services at an emergency department for a health condition that could have been prevented or treated in a non-emergency setting.[282] The AHCA has identified a variety of causes that may result in these visits, e.g., failure to access primary care, lack of ambulatory care coordination, monitoring, or follow-up, inadequate and/or inaccessible nursing care for a nursing sensitive condition, etc.[283]

Throughout federal fiscal year (FFY) 2019-2020, 294,220 potentially preventable emergency department visits were identified, compared to 388,257 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[284]

- Upper respiratory infections/otitis;
- Gastrointestinal diagnoses;
- Skin traumas;
- Abdominal pain;
- Viral illnesses;
- Level II musculoskeletal diagnoses;

[281] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).
[282] *Id*.
[283] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).
[284] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Emergency Room Visits (PPVs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPVsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).

- Level I respiratory diagnoses;
- Lower urinary tract infections;
- Skin tissue conditions; and
- Fevers.

Potentially Preventable Hospital Admissions

Potentially preventable hospital admissions are when a patient is admitted for necessary treatment to an acute care hospital[285], but the admission could have been avoided, or when a patient is admitted and could have been treated outside of an inpatient hospital setting.[286]

Throughout federal fiscal year (FFY) 2019-2020, 71,541 potentially preventable hospital admissions were identified, compared to 67,048 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[287]

- Septicemia;
- Heart failure;
- Pneumonia diagnoses;
- Chronic obstructive pulmonary disease;
- Major respiratory infections;
- Infectious diseases;
- Urinary tract infections/kidney infections;
- Cardiac defibrillation;
- Seizures; and
- Dorsal/lumbar fusions.

Potentially Preventable Hospital Readmissions

Potentially preventable hospital readmissions are when a patient is readmitted to an acute care hospital for a reason that is clinically related to the initial hospitalization or from deficiencies in a post-hospital discharge follow-up after a prior acute care admission[288] within thirty days of a hospital discharge.[289]

Throughout FFY 2019-2020, 30,593 PPEs were identified with at least one potentially preventable hospital readmission, compared to 31,689 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[290]

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[285] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).

[286] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).

[287] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Hospital Admissions (PPAs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPAsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).

[288] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).

[289] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).

[290] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Readmissions (PPRs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPRsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 8, 2024).

- Schizophrenia;
- Bipolar disorders;
- Major depression;
- Septicemia;
- Heart failure;
- Sickle cell crises;
- Chronic obstructive pulmonary disease;
- Diabetes;
- Cesarean deliveries; and
- Child behavior disorders.

Effect of the bill - Potentially Preventable Health Care Events (PPEs)

The bill amends s. 409.967, F.S., to require the AHCA to produce a report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees" annually. The report must include an analysis of the potentially preventable hospital emergency department visits, admissions, and readmissions that occurred during the previous state fiscal year, reported by age, eligibility group, managed care plan, and region, including conditions contributing to each PPE or category of PPEs.

The bill authorizes the AHCA to include any other data or analysis parameters necessary to augment the report, and requires trend demonstrations be included in the report using historical data and requires the AHCA to submit this report annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The bill authorizes the AHCA to contract with a third-party vendor to produce the report.

Acute Hospital Care at Home (AHCAH) Initiative

Hospitals are licensed and regulated pursuant to ch. 395, F.S., by the Agency for Health Care Administration (AHCA). In addition, the federal Centers for Medicare and Medicaid Services establish standards for hospitals to be eligible to treat (and receive payment for) Medicare patients, called Conditions of Participation.

In November, 2020, as part of the *Hospital Without Walls Initiative* to address the COVID-19 public health emergency and concerns about hospital bed capacity, the federal Centers for Medicare and Medicaid Services (CMS) began issuing waivers to eligible hospitals authorizing the practice of acute hospital care at home under the Acute Hospital Care at Home Program (Program).[291] Specifically, CMS waived s. 482.23(b) and (b)(1) of the Medicare Hospital Conditions of Participation, in effect suspending the requirement for nursing services to be provided on premises 24 hours a day, seven days a week, and for the immediate availability of a registered nurse. In December, 2022, CMS extended the program from the first day after the end of the national public health emergency until December 31, 2024.[292] There is speculation that the Program might become permanent.[293]

These authorizations effectively allow hospitals to provide an inpatient level of care to certain patients in their homes.[294] The Program treats patients who require acute inpatient admission to a hospital and at least daily rounding by a physician and a medical team monitoring the patient's care needs on an

[291] Centers for Medicare and Medicaid Services, Press Release – CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge, https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge (last visited January 8, 2024).
[292] 42 U.S.C. §1395cc-7 (2022).
[293] Bill Siwicki, Healthcare IT News, *Will CMS' Acute Hospital Care at Home Waiver Program Become Permanent?* (August 28, 2023), available at https://www.healthcareitnews.com/news/will-cms-acute-hospital-care-home-waiver-program-become-permanent#:~:text=Even%20with%20the%20public%20health,including%20hospital%2Dat%2Dhome (last visited January 8, 2024).
[294] A patient's home is his or her permanent residence, which includes assisted living, but does not include nursing homes.

ongoing basis.[295] Treatment for more than 60 acute conditions, such as asthma, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease, may be provided through the Program.[296] Patient participation in the program is voluntary.[297]

To receive a waiver and participate in the Program, a hospital must:[298]

- Have appropriate screening protocols in place before care at home begins to assess both medical and non-medical factors;
- Have a physician or advanced practice provider evaluate each patient daily either in-person or remotely;
- Have a registered nurse evaluate each patient once daily either in-person or remotely;
- Have two in-person visits daily by either registered nurses or mobile integrated health paramedics based on the patient's nursing plan and hospital policies;
- Have the capability of immediate, on-demand remote audio connection with an Acute Hospital Care at Home team member who can immediately connect either an RN or MD to the patient;
- Have the ability to respond to a decompensating patient within 30 minutes;
- Track several patient safety metrics with weekly or monthly reporting, depending on the
- hospital's prior experience level;
- Establish a local safety committee to review patient safety data;
- Use an accepted patient leveling process to ensure that only patients requiring an acute level of care are treated; and
- Providing or contracting for other services required during an inpatient hospitalization.

Programs must obtain a waiver from AHCA rule requiring only registered nurses to conduct evaluations in order for paramedics to conduct such in-person visits.[299] As of December 14, 2023, 308 hospitals in 37 states have Acute Hospital Care at Home Programs. There are 12 hospitals in Florida approved to participate in the Program, including:[300]

- Mayo Clinic Florida;
- Cleveland Clinic Hospital;
- Cleveland Clinic Martin North;
- Cleveland Clinic Indian River;
- Palm Bay Hospital;
- Holmes Regional Medical Center;
- Viera Hospital;
- Cape Canaveral Hospital;
- Keralty Hospital;
- Tampa General Hospital;
- Orlando Regional Medical Center; and
- AdventHealth Orlando.

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[295] *Supra*, note 291.
[296] Id.
[297] Centers for Medicare and Medicaid Services, *Acute Hospital Care at Home Frequently Asked Questions,* https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab2 (last visited January 8, 2024).
[298] Centers for Medicare and Medicaid Services, Acute Hospital Care at Home Program Approved List of Hospitals as of 4/5/2021, available at https://www.cms.gov/files/document/covid-acute-hospital-care-home-program-approved-list-hospitals.pdf (last visited January 8, 2024).
[299] Programs must obtain an AHCA waiver for Rule 59A-3.243(4)(c) and (6), F.A.C., relating to nursing services.
[300] Id.

Effect of the bill - Acute Hospital Care at Home (AHCAH) Initiative

The bill requires AHCA to seek the federal approval necessary to implement an Acute Hospital Care at Home Program under the state Medicaid program, and requires the Program to be substantially consistent with the temporary Program currently authorized by CMS.

Inherent within the foundation of these programs, is that the primary payors for services are Medicare and Private Insurance. The Medicaid population that would be eligible for services under an Acute Hospital Care at Home Program is unknown, but is likely minimal.

Access to Health Care Act

Section 766.1115, F.S., creates the "Access to Health Care Act" to provide protections against liability for health care providers who offer free quality medical services to underserved populations in Florida. The act provides that a health care provider that executes a contract with a governmental contractor[301] to provide health care services is considered an agent of the state for sovereign immunity purposes when acting under the scope of duties under the contract and may not be named as a defendant in any action arising out of medical care or treatment provided under the contracts entered into.

For the purposes of the Access to Health Care Act, a health care provider includes:

- A birth center.
- An ambulatory surgical center.
- A hospital.
- A medical doctor, osteopathic physician, or PA.
- A chiropractic physician.
- A podiatric physician.
- A registered nurse, nurse midwife, licensed practical nurse (LPN), or APRN or any facility which employs nurses to supply all or part of the care delivered.
- A midwife.
- A health maintenance organization.
- A health care professional association and its employees or a corporate medical group and its employees.
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
- A dentist or dental hygienist.
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the listed professionals.

[301] The Access to Health Care Act defines "governmental contractor" as DOH, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity. s. 766.1115(3)(c), F.S.

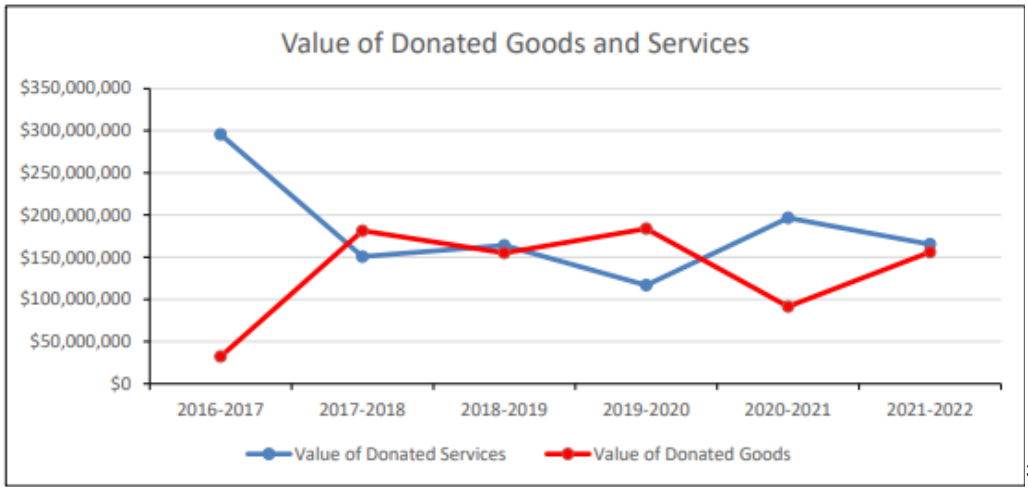
Volunteer Health Care Provider Program

Through the Access to Health Care Act, DOH established the Volunteer Health Care Provider Program (Program). The Program improves access to free medical and dental services for uninsured and underserved low-income residents.[302] For the purposes of the Act, low-income means:[303]

- A person who is Medicaid-eligible under Florida law;
- A person without health insurance and whose family income does not exceed 200 percent of the federal poverty level (FPL) as defined annually be the federal Office of Management and Budget; or
- Any client of DOH who voluntarily chooses to participate in a DOH-offered or DOH-approved program and who meets program eligibility requirements.

The governmental contractor or health care provider will determine and approve client eligibility based on these three eligibility groups.[304] The Program trains non-licensed volunteers to determine eligibility and refer individuals to providers for primary or specialty care. According to DOH's annual report for FY21-22, DOH maintained 1,382 eligibility and referral specialists.[305] In addition, any federally funded community health center and any volunteer corporation or volunteer health care provider that delivers health care services are also included.[306] The health care providers participating in the Program primarily are community and faith-based medical clinics.[307] In FY21-22, DOH reports a total of 219 community and faith-based clinics and organizations with 10,043 licensed health care professionals.[308]

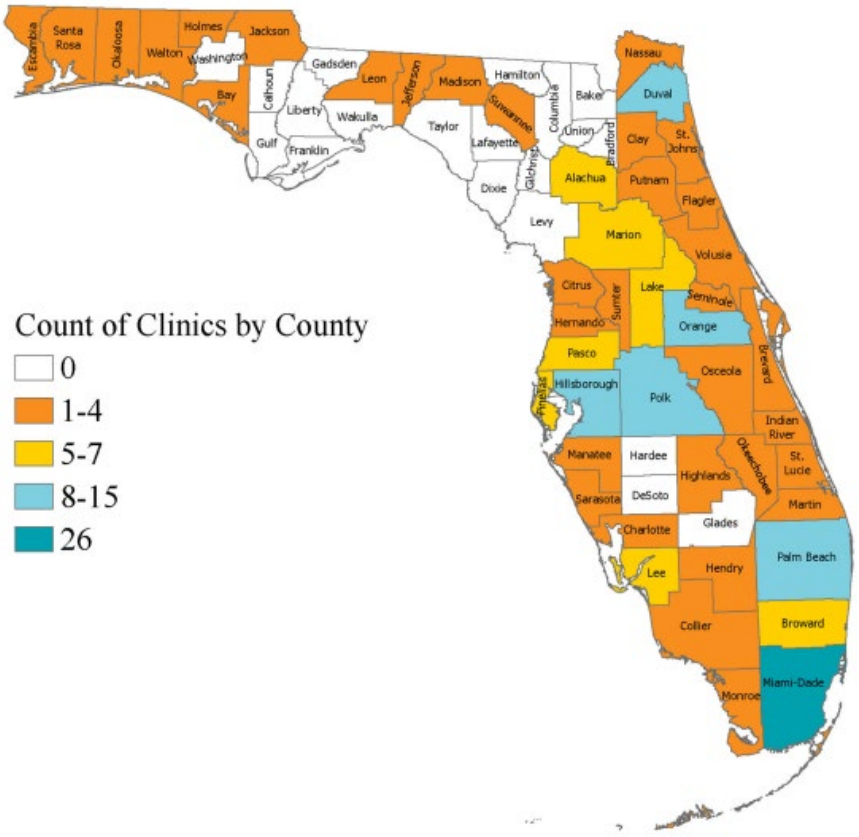
Since the inception of the Volunteer Health Care Provider Program (Program) in 1992, DOH documented more than $4.9 billion in donated goods and services.[309] For FY21-22, DOH reports the value of health-related goods and services totaled more than $321 million.[310] As illustrated in the graph below, the value of 872,653 donated hours amongst all clinics and organizations is $165 million, and the value of the donations of money, supplies, and equipment received by 140 clinics and organizations is $156 million.[311]



[312]

[302] Florida Dept. of Health, *Volunteer Heath Care Provider Program Annual Report Fiscal Year 2021-22*, p. 2 (Dec. 2022) https://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/vhs2122annualreport.pdf (last visited January 8, 2024).
[303] Section 766.1115(3)(e), F.S.
[304] R. 64I-2.002(1), F.A.C.
[305] *Id*. at 1.
[306] Section 766.1115(3)(d), F.S.
[307] *Supra*, FN 2 at 2.
[308] *Id*. at 1.
[309] *Id*.
[310] *Id*.
[311] *Id*. at 8.
[312] *Id*.

During FY21-22, an aggregate total of 443,971 health care services were provided to eligible individuals.[313] The number of counties with participating clinics and organizations increased from 44 to 47.[314] The county-by-county map below depicts which counties the Program served during FY21-22 and the number of participating health care providers per county.



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Sovereign Immunity

Sovereign immunity means a government is immune from being sued in its own courts without its consent.[316] The Florida Constitution grants absolute sovereign immunity to the state and its agencies.[317] At its discretion, Florida may waive sovereign immunity for any cause of action by legislative enactment or constitutional amendment.[318]

Florida waived sovereign immunity in tort actions.[319] Specifically, a tort action against the state for damages is available to remedy injury or loss of property, personal injury, or death caused by the negligent or wrongful act or omission of any state government personnel while acting within the scope

[313] *Id*. at 1.
[314] *Id*. at 4. DOH intends to increase Program service to 55 counties by December 30, 2025. Eight clinics closed in FY21-22 and did not provide any volunteer services.
[315] *Id*. at 5.
[316] Bryan Garner, *Immunity (1) – Sovereign Immunity (1)*, Black's Law Dictionary, 11th ed. 2019, Accessed Westlaw Dec. 16, 2023.
[317] *Circuit Court of Twelfth Judicial Circuit v. Dep't of Nat'l Resources*, 339 So.2d 1113, 1114 (Fla. 1976); "Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating." Art. X, s. 13, *Fla. Const*.
[318] *Circuit Court of Twelfth Judicial Circuit*, 339 So.2d at 1114.
[319] s. 768.28(1), F.S.

of their employment.[320] A state government "officer, employee, or agent" includes any health care provider when providing services under the Access to Health Care Act.[321]

The state currently caps damages in suits against the state at $200,000 per person and $300,000 per incident.[322] MQA reports zero claims filed against the Program since March 2012.

Effect of the bill - Access to Health Care Act

The bill increases the maximum family income allowable under the Program to receive free medical and dental services for uninsured and underserved low-income residents from those whose family income does not exceed 200% of the federal poverty level to those whose family income does not exceed 300% of the federal poverty level. This change will increase the number of people eligible for services under the Program while allowing the providers to retain sovereign immunity protections.

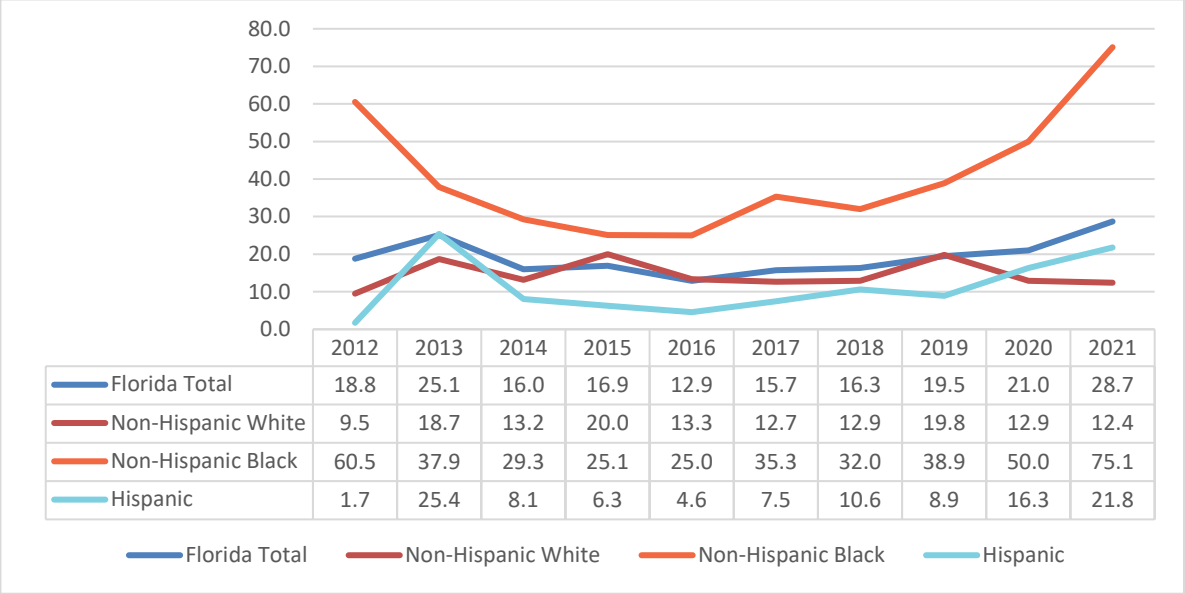
Telehealth Minority Maternity Care Pilot Program

Maternal Mortality and Morbidity

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[323] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019.[324] The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births.[325] Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.[326] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[327]

[320] *Id*.
[321] Sections 768.28(9)(2); 766.1115(4), F.S.
[322] Section 768.28(5)(a), F.S. For a plaintiff to overcome the cap on damages, the Legislature may enact a claims bill to cover the balance of a judgment in excess of the cap or the state agency can settle a judgment rendered against within the limits of the agency's insurance coverage.
[323] U.S. Dep't of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health*, (Dec. 2020), available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (last visited December 5, 2023).
[324] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021,* (March 2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf (last visited January 8, 2024).
[325] *Id*.
[326] *Id*.
[327] United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic*, (Oct. 2022), available at https://www.gao.gov/assets/gao-23-105871.pdf (last visited December 5, 2023).

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.[328] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida as evidenced in the following chart:



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Florida Total	18.8	25.1	16.0	16.9	12.9	15.7	16.3	19.5	21.0	28.7
Non-Hispanic White	9.5	18.7	13.2	20.0	13.3	12.7	12.9	19.8	12.9	12.4
Non-Hispanic Black	60.5	37.9	29.3	25.1	25.0	35.3	32.0	38.9	50.0	75.1
Hispanic	1.7	25.4	8.1	6.3	4.6	7.5	10.6	8.9	16.3	21.8

Severe Maternal Morbidity

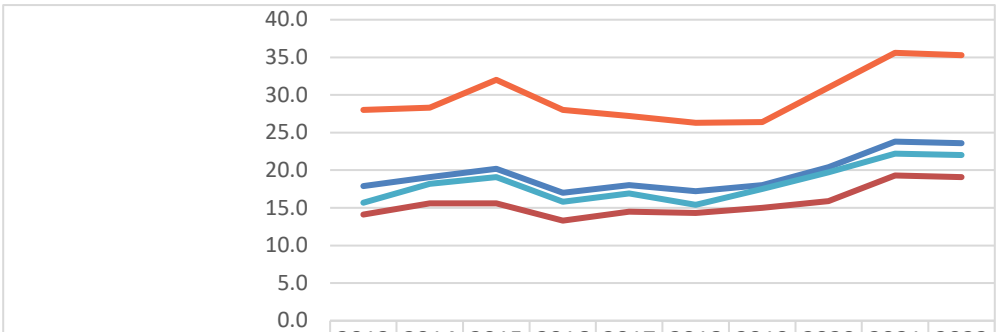
For every maternal death, 100 women suffer a severe obstetric morbidity, a life-threatening diagnosis, or undergo a lifesaving procedure during their delivery hospitalization.[329] Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SMM has been steadily increasing in recent years.[330]

The consequences of the increasing SMM prevalence, in addition to the health effects for the woman, are wide-ranging and include increased medical costs and longer hospitalization stays.[331] The leading causes of SMM in 2021 were:

- Blood transfusion;
- Disseminated intravascular coagulation;
- Acute renal failure;
- Sepsis;
- Adult respiratory distress syndrome;
- Hysterectomy;
- Shock;
- Ventilation; and
- Eclampsia.[332]

[328] Presentation by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 8, 2024).
[329] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), available at https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited January 8, 2024).
[330] *Id.,* and CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 8, 2024).
[331] CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 8, 2024).

From 2013 to 2022, there were 51,454 cases of SMM among delivery hospitalization in Florida.[333] The following figure shows the trend over time for SMM rates in Florida per 1,000 delivery



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Florida Total	17.9	19.1	20.2	17.0	18.0	17.2	18.0	20.4	23.8	23.6
Non-Hispanic White	14.1	15.6	15.6	13.3	14.5	14.3	15.0	15.9	19.3	19.1
Non-Hispanic Black	28.0	28.3	32.0	28.0	27.2	26.3	26.4	31.0	35.6	35.3
Hispanic	15.7	18.2	19.1	15.8	16.9	15.4	17.5	19.7	22.2	22.0

hospitalizations:[334]

Similar to maternal mortality rates, rates of SMM are higher in racial and ethnic minority women.[335]

Telehealth Minority Maternity Care Pilot Program

In 2021, the Legislature created the Telehealth Minority Maternity Care Pilot Program in Duval and Orange counties to increase positive maternal health outcomes in racial and ethnic minority populations.[336]

DOH received funding in the 2023-2024 FY[337] to expand the pilot program to an additional 18 counties.[338] The additional counties are Brevard, Broward, Collier, Escambia, Hillsborough, Lake, Lee, Leon, Manatee, Marion, Miami-Dade, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, and Volusia.

The pilot programs use telehealth to coordinate with prenatal home visiting programs to provide the following services and education to eligible pregnant women[339] up to the last day of their postpartum period:

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[332] Florida Perinatal Quality Collaborative, *Opportunities for Florida Hospital Participation*, (Aug. 23, 2022), available at https://health.usf.edu/-/media/Files/Public-Health/Chiles-Center/FPQC/FPQC-Informational-Webinar-FINAL-23-AUG-22.ashx?la=en&hash=93B16B88819045E16DA5C84EEE3A6C416B3E457A (last visited January 8, 2024).
[333] Presentation by Kenneth Scheppke, M.D., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 8, 2024).
[334] *Id.*
[335] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), available at https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited January 8, 2024).
[336] Chapter 2021-238, Laws of Florida, codified at s. 381.2163, F.S.
[337] Chapter 2023-239, Laws of Florida, line item 435.
[338] Florida Department of Health, Office of Minority Health, *Request for Applications: Programs to Reduce Severe Maternal Morbidity through Telehealth (SMMT) in Florida, RFA #22-002*, (April 19, 2023), available at https://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/RFA22-002.pdf#Open%20in%20new%20window (last visited January 8, 2024).
[339] An "eligible pregnant woman" is a pregnant woman who is receiving, or is eligible to receive, maternal or infant services from the DOH under ch. 381, F.S. or ch. 383, F.S.

- Referrals to Healthy Start's[340] coordinated intake and referral program to offer families prenatal home visiting services;
- Services and education addressing social determinants of health;[341]
- Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in prenatal and postpartum periods;
- For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers; and
- Medical devices for prenatal women to conduct key components of maternal wellness checks.[342]

The pilot programs also provide training to participating health care practitioners on:

- Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers;
- The use of remote patient monitoring tools;
- How to screen for social determinants of health risks in prenatal and postpartum periods;
- Best practices to screen for, evaluate, and treat mental health conditions and substance use disorders, as needed; and
- Collection of information, recording, and evaluation activities for program and patient evaluations.[343]

According to DOH, since the program's implementation, it has served more than 2,500 women in Duval and Orange counties, and 95 percent of the participants have reported that the program addressed an unmet social need.[344] The five most prevalent critical factors were food scarcity, childcare, paid work opportunities, affordability and access to utilities such as the Internet, and access to stable housing.

Additionally, 71 percent of the enrolled women in Duval County and 85 percent of enrolled women in Orange County reported high satisfaction with the implementation of the technology in the pilot program.[345] The enrolled women were provided blood pressure cuffs, scales, and glucose monitors to remotely screen and treat common pregnancy-related complications.

Effect of the bill - Telehealth Minority Maternity Care Pilot Program

The bill expands the current Telehealth Minority Maternity Care pilot program into a statewide program and, beginning October 31, 2025, requires the DOH to annually report on the program to the Governor and the Legislature. The annual report, which is due each October 31, must include, at a minimum, all of the following from the previous fiscal year:

- The total number of clients served and demographic information for the population served, including ethnicity and race, age, education levels, and geographic location;
- The total number of screenings performed, by type;

[340] Healthy Start is a free home visiting program that provides education and care coordination to pregnant women and families of children under the age of three. The goal of the program is to lower risks factors associated with preterm birth, low birth weight, infant mortality, and poor development outcomes. *See* DOH, *Healthy Start*, available at https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html (last visited January 8, 2024).
[341] Social determinants of health refer to the conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. They are grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environments, and social and community context. *See* U.S. Dep't of Health and Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health*, available at https://health.gov/healthypeople/priority-areas/social-determinants-health (last visited January 8, 2024).
[342] Section 383.2163(3), F.S.
[343] Section 383.2163(4), F.S.
[344] Email correspondence the DOH dated October 30, 2023 (on file with the Senate Committee on Health Policy).
[345] *Id.*

- The number of participants identified as having experienced pregnancy-related complications, the number who received treatments for such complications, and the final outcome of the pregnancy for such participants;
- The number of referrals made to Healthy Start and other prenatal home visiting programs and the number of participants who ultimately received services from such programs;
- The number of referrals made to doulas and other perinatal professionals and the number of participants who subsequently received such services;
- The number and types of devices provided to participants to conduct wellness checks;
- The average length of participation by program participants;
- Composite results of a participant survey that measures the participants' experience with the program;
- The total number of health care practitioners trained by provider type and specialty;
- The results of a survey of health care practitioners trained under the program. The survey must address the quality and impact of the training provided, the healthcare practitioners experiences using remote patient monitoring tools, the best practices provided in the training, and any suggestions for improvement;
- Aggregate data on the maternal and infant health outcomes of program participants; and
- For the initial report, all available quantifiable data related to the pilot program.

The bill appropriates $29,760,062 in recurring funds from the General Revenue Fund to the Grants and Aids – Minority Health Initiative Category, to the DOH to expand the telehealth minority maternity care program statewide.

Health Care Screening

The Florida Statutes contain numerous health screening programs, such as:

Section Number	Type of Screening	Text or Summary	Agency in Charge
381.815	Sickle-Cell disease	"Work cooperatively with not-for-profit centers to provide community-based education, patient teaching, and counseling and to encourage diagnostic screening."	DOH
381.0038	Requires needle exchange programs to provide HIV and hepatitis screenings, or referrals. Not state operated or funded.	"An exchange program must: Provide onsite counseling or referrals for drug abuse prevention, education, and treatment, and provide onsite HIV and viral hepatitis screening or referrals for such screening. If such services are offered solely by referral, they must be made available to participants within 72 hours."	DOH, however exchange programs are not state operated or funded.
381.004	HIV Testing	Requires the DOH to run HIV screening programs in each county.	DOH

381.0056	School Health Screenings	Includes vision, hearing, scoliosis, growth and development, health counseling, referrals for suspected or confirmed health problems, and preventative dental program.	County Health Departments in conjunction with District School Boards
381.91	Cancer Screenings	Community faith-based disease-prevention program to offer cancer screening, diagnosis, education, and treatment services to low-income populations throughout the state.	DOH operated from community health centers within the Health Choice Network
381.93	Breast and Cervical Cancer	"Mary Brogan Breast and Cervical Cancer Early Detection Program." The Department of Health, using available federal funds and state funds appropriated for that purpose, is authorized to establish the Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program to provide screening, diagnosis, evaluation, treatment, case management, and follow-up and referral to the Agency for Health Care Administration for coverage of treatment services.	DOH
381.932	Breast Cancer	"Breast cancer early detection and treatment referral program." The purposes of the program are to: (a) Promote referrals for the screening, detection, and treatment of breast cancer among unserved or underserved populations. (b) Educate the public regarding breast cancer and the benefits of early detection. (c) Provide referral services for persons seeking treatment. "Underserved Population" defined as: 1. At or below 200 percent of the federal poverty level for individuals; 2. Without health insurance that covers breast cancer screenings; and 3. Nineteen to 64 years of age, inclusive.	DOH
381.96	Wellness Screenings for women	"Wellness services" means services or activities intended to maintain and improve health or prevent illness and injury, including, but not limited to,	Pregnancy Care Network (Contracted by DOH).

		high blood pressure screening, anemia testing, thyroid screening, cholesterol screening, diabetes screening, and assistance with smoking cessation.	
381.985	Lead Poisoning	Lead poisoning screenings for children at risk for exposure to lead.	DOH
383.011, 383.14-383.147	Newborn Screenings	Various required test for newborns and infants.	DOH
385.103	Cancer, diabetes, heart disease, stroke, hypertension, renal disease, and chronic obstructive lung disease.	Chronic Disease Intervention Programs The department shall assist the county health departments in developing and operating community intervention programs throughout the state. At a minimum, the community intervention programs shall address one to three of the following chronic diseases: cancer, diabetes, heart disease, stroke, hypertension, renal disease, and chronic obstructive lung disease. Uses community funding, gifts, grans, and other funding. Requires volunteers to be used to the maximum extent possible.	DOH
385.206	Hematology-Oncology Sickle-cell anemia	Allows DOH to make grants and reimbursements to designated centers to establish and maintain programs for the care of patients with hematologic and oncologic disorders. Requires such programs to offer screenings and counseling for patients with sickle-cell anemia or other hemoglobinopathies.	DOH, through grants
392.61	Tuberculosis	DOH is required to operate TB control programs in each state including community and individual screenings	DOH

Effect of the bill - Health Care Screening

The bill creates s. 381.9855, F.S., to require the DOH to implement a Health Care Screening and Services Grant Program (HCSSGP). The purpose of the HCSSGP is to fund the provisions of no-cost health care screenings or services for the general public by nonprofit entities. The bill requires the DOH to:

- Publicize the availability of funds and enlist the aid of county health departments for outreach to potential applicants at the local level.
- Establish an application process for submitting a grant proposal and criteria an applicant must meet to be eligible.
- Develop guidelines a grant recipient must follow for expenditure of grant funds and uniform data reporting requirements for the purpose of evaluating the performance of grant recipients.

A nonprofit entity may apply for grant funding to implement new health care screening or services programs or to provide the same or similar screenings that it is currently providing in new locations or through a mobile health clinic or mobile unit in order to expand the program's delivery capabilities. Entities that receive funding under the HCSSGP are required to:

- Follow DOH guidelines for reporting on expenditure of grant funds and measures to evaluate the effectiveness of the entity's health care screening or services program; and
- Publicize to the general public and encourage the use of the health care screening portal created by the section.

The bill requires the DOH to create and maintain an Internet-based portal, with a clear and conspicuous link on the home page of its website, to direct the general public to events, organizations, and venues from which health care screenings or services may be obtained at no cost or at a reduced cost and to direct licensed health care practitioners to opportunities to volunteer their services for such screenings and services. The bill authorizes the DOH to contract with a third-party vendor for the portal.

The portal must be easily accessible by the public, not require a sign-up or login, and include the ability for a member of the public to enter his or her address and obtain localized and current data on opportunities for screenings and services and volunteer opportunities for health care practitioners. The portal is required to include all statutorily created screening programs that are funded and operational under the DOH's authority. The DOH is required to coordinate with county health departments (CHD) to include screenings and services provided by the CHDs or by nonprofit entities in partnership with the CHDs.

Florida Center for Nursing

Current Situation

In 2001, the Florida Legislature created s. 464.0195, F.S., establishing the Florida Center for Nursing "to address issues of supply and demand for nursing, including issues of recruitment, retention, and utilization of nurse workforce resources." The primary statutory goals address collecting and analyzing nursing workforce data; developing and disseminating a strategic plan for nursing; developing and implementing reward and recognition activities for nurses; and promoting nursing excellence programs, image building, and recruiting into the profession.

The Florida Center for Nursing conducts an analysis of licensed practical nurses, registered nurses, and advanced practice registered nurses annually to assess Florida's nurse supply, including the numbers of nurses, demographics, education, employment status, and specialization pursuant to s. 467.019, F.S. The Florida Center for Nursing is required to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 30 each year through January 30, 2025.

Effect of the bill – Florida Center for Nursing

The current requirement for the Florida Center for Nursing to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, will sunset after the report that is due on January 30, 2025. The bill deletes that sunset date, providing that the report will be due each January 30 in perpetuity.

Linking Industry to Nursing Education

Established by the Legislature in 2022, the Linking Industry to Nursing Education (LINE) fund is a competitive grant program intended to address critical nursing workforce needs by incentivizing collaboration between nursing education programs and healthcare partners.[346] The LINE fund provides matching funds on a dollar-to-dollar basis, subject to funds availability, to participating institutions that partner with a healthcare provider to meet local, regional, and state workforce needs.[347] LINE funds may be used for resident student scholarships, recruitment of additional faculty, equipment, and simulation centers to advance high-quality nursing education programs throughout the state.[348] LINE funds may not be used for the construction of new buildings.[349]

In order to be eligible to receive LINE funds, an institution[350] must have a nursing education program that meets certain, specified criteria. Among the criteria is a minimum program completion rate or first-time passage rate on the National Council of State Boards of Nursing Licensing Examination (NCLEX). Specifically, the institution must have a nursing education program that meets or exceeds the following[351]:

- For a certified nursing assistant program, a completion rate of at least 70 percent for the prior year.
- For a licensed practical nurse, associate of science in nursing and bachelor of science in nursing program, a first-time passage rate on the National Council of State Boards of Nursing Licensing Examination of at least 70 percent for the prior year.

The LINE fund is administered by the Board of Governors (BOG) for State University System (SUS) institutions and the Department of Education (DOE) for all other institutions. Per DOE, non-SUS institutions with more than one nursing education program must demonstrate that at least one active program meets or exceeds the completion or passage rate criterion.[352] Additionally, school districts with more than one career center are not required to meet performance metrics for all operating career centers; however, LINE funds may only be expended at the career centers that meet or exceed the completion or passage rate criterion.[353] Additionally, per DOE guidance applicable to non-SUS institutions, new nursing education programs may not be used to determine eligibility.[354]

An institution that wishes to receive LINE funds must submit a timely and complete proposal to the BOG or DOE, as applicable.[355] The proposal must identify a healthcare partner[356] located and licensed to operate in the state whose monetary contributions will be matched on a dollar-to-dollar basis.[357]

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[346] Section 1009.8962, F.S.
[347] Section 1009.8962(5), F.S.
[348] Section 1009.8962(6)(a), F.S.
[349] Section 1009.8962(6)(b), F.S.
[350] For purposes of the LINE program, 'institution' means a school district career center under s. 1001.44, a charter technical career center under s. 1002.34, a Florida College System institution, a state university, or an independent nonprofit college or university located and chartered in this state and accredited by an agency or association that is recognized by the database created and maintained by the United States Department of Education to grant baccalaureate degrees, which has a nursing education program that meets or exceeds certain, specified completion rates or licensure passage rates. *See* s. 1009.8962(3)(b), F.S.
[351] Section 1009.8962(3)(b), F.S.
[352] *See* Florida Department of Education 'Notice of Intent-To-Apply Form, Linking Industry to Nursing Education (LINE)' here. (Last visited December 20, 2023).
[353] Id.
[354] *See* 'Linking Industry to Nursing Education (LINE) Fund Frequently Asked Questions,' question #28, here. (Last visited December 20, 2023).
[355] Section 1009.8962(7)(a), F.S.
[356] For purposes of the LINE program, a 'healthcare partner' is defined a provider as defined in s. 408.803, F.S.; a clinical laboratory providing services in this state or services to health care providers in this state, if the clinical laboratory is certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; federally qualified health center as defined in 42 U.S.C. s. 1396d(l)(2)(B), as that definition existed on March 29, 2021; any site providing health care services which was established for the purpose of responding to the COVID-19 pandemic pursuant to any federal or state order, declaration, or waiver; a health care practitioner as defined in s. 456.001; a health care professional licensed

The BOG or DOE, as applicable, must review and evaluate each completed and timely proposal according to the following minimum criteria[358]:

- Whether funds committed by the health care partner will contribute to an eligible purpose.
- How the institution plans to use the funds, including how such funds will be utilized to increase student enrollment and program completion.
- How the health care partner will onboard and retain graduates.
- How the funds will expand the institution's nursing education programs to meet local, regional, or state workforce demands. If applicable, this shall include advanced education nursing programs and how the funds will increase the number of faculty and clinical preceptors and planned efforts to utilize the clinical placement process.

Per BOG regulation, additional criteria for universities may be established by the SUS Chancellor as needed.[359] BOG regulation also states the BOG will award funding based on the merit of each proposal, funds may be awarded on a first-come, first-served basis, and award amounts may be prorated depending on the number of approved proposals and the dollar amounts requested.[360] Per State Board of Education rule, the DOE, for all non-SUS proposals, will also consider the strength of the proposed programs, the geographic location of the proposals and statewide workforce demands in order to promote the distribution of funds and avoid a concentration of funds in a small number of institutions.[361]

Each institution with an approved proposal is required to notify the BOG or DOE, as applicable, upon receipt of the funds from the healthcare partner identified in the proposal. Once notified, the BOG or DOE, as applicable is required to release the LINE funds, on a dollar-to-dollar basis, up to the amount of funds received by the institution.

Annually, by February 1, each institution awarded LINE funds in the previous fiscal year is required to submit a report to the BOG or DOE, as applicable, that demonstrates the expansion as outlined in the proposal and the use of the funds. At minimum, the report must include, by program level, the number of additional nursing education students enrolled; if scholarships were awarded using grant funds, the number of students who received scholarships and the average award amount; as well as student outcomes.

For Fiscal Years 2022-2023 and 2023-2024, the Florida Legislature allocated $6 million in LINE funding each year to the State University System.[362] For Fiscal Year 2022-2023, the BOG approved proposals from eight state universities across two application submission periods.[363] For Fiscal Year 2023-2024, proposals submitted by nine state universities were approved as of December 2023.[364] The requested funds for these proposals were primarily intended to fund student scholarships, simulation centers, and faculty salaries.[365]

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under part IV of chapter 468; a home health aide as defined in s. 400.462(15); a provider licensed under chapter 394 or chapter 397 and its clinical and nonclinical staff providing inpatient or outpatient services; a continuing care facility licensed under chapter 651; a pharmacy permitted under chapter 465. *See* s. 768.38(2), F.S.

[357] Section 1009.8962(7)(b), F.S.

[358] Section 1009.8962(8), F.S.

[359] BOG Regulation 8.008(1)(d)2.

[360] Id.

[361] Rule 6A-10.0352(5)(b), F.A.C.

[362] Specific Appropriation 143A, Ch. 2022-156, L.O.F. and Specific Appropriation 142, Ch. 2023-239, L.O.F.

[363] *See* State University System of Florida Board of Governors meeting documents for September 14, 2022, here and November 9, 2022, here. (last viewed December 19, 2023). (Last visited January 8, 2024).

[364] *See* State University System of Florida Board of Governors meeting documents for September 8, 2023, here and November 9, 2023, here. (last viewed December 19, 2023). (Last visited January 8, 2024).

[365] *See* State University System of Florida Board of Governors meeting presentations for September 13, 2022, here, November 9, 2022, here, September 8, 2023, here, and November 9, 2023, here.

For Fiscal Years 2022-2023 and 2023-2024, the Florida Legislature allocated $19 million in LINE funding each year to the Department of Education to fund proposals from Florida's public-school districts (career centers), Florida College System institutions, and independent nonprofit colleges and universities. For Fiscal Year 2022-2023, proposals submitted by 26 school districts and institutions were approved.[366]

Florida's public career centers, state colleges, state universities, and independent nonprofit colleges and universities that meet the minimum completion or passage rates have been eligible since the LINE Fund's inception. The 2023-2024 General Appropriations Act appropriated $5 million in nonrecurring funds to accredited private educational institutions that meet the same criteria as the public career centers, state colleges, state universities, and other private colleges and universities that are eligible for the LINE program.[367]

Effect of the bill - Linking Industry to Nursing Education

The bill expands the statutory LINE Fund program to include independent schools, colleges, or universities with an accredited nursing program that is located in and chartered by Florida and is licensed by the Commission for Independent Education. Pursuant to the bill, 'accredited program' means a program for the prelicensure education of professional or practical nurses that is conducted in the United States at an educational institution, whether in this state, another state, or the District of Columbia, and that is accredited by a specialized nursing accrediting agency that is nationally recognized by the United States Secretary of Education to accredit nursing education programs.

The also bill increases the passage rate for the NCLEX, from 70 percent to 75 percent, that is required for LPN, associate of science in nursing, and bachelor of science in nursing programs in order to be eligible to participate in the program and receive LINE funds. Additionally, the bill requires the passage rate be based on a minimum of 10 testing participants.

Developmental Research Laboratory Schools

Developmental research laboratory schools (lab schools) are an established category of public schools that provide sequential instruction and are affiliated with a college of education within the state university of closet geographic proximity.[368] Lab schools are required to establish admission processes that are designed to result in a representative sample of the public school enrollment based on gender, race, socioeconomic status, and academic ability.[369] As part of a lab school's mission, there must be an emphasis on mathematics, science, computer science, and foreign languages.[370] Additionally, as part of the lab school's primary goal, the school is required to enhance instruction and research in such specialized subjects by using the resources available on the university's campus. Currently, there are four universities that have lab schools:[371]

- Florida Atlantic University
- Florida State University
- Florida Agricultural and Mechanical University
- University of Florida

[366] *See* '2022-2023 LINE Fund Prioritized Funding List,' here. (Last visited January 8, 2024).
[367] Specific Appropriation 58, Ch. 2023-239, L.O.F.
[368] Section 1002.32(2), F.S.
[369] Section 1002.32(4), F.S.
[370] Section 1002.34(3), F.S.
[371] Florida Department of Education, *Superintendents,* https://www.fldoe.org/accountability/data-sys/school-dis-data/superintendents.stml (last visited January 8, 2024)

A university is limited to one lab school, except for a charter lab school or one that serves military families near a military installation.[372] State universities operate four charter lab schools, which are Florida State University Charter Lab K-12 School in Broward County, Florida Atlantic University Charter Lab K-12 School in Palm Beach County, Florida Atlantic University Charter Lab K-12 School in St. Lucie County[373]and the Florida State University Collegiate School in Bay County.[374] In considering an application to establish a charter lab school, a state university must consult with the district school board of the county in which the school is located. If a state university denies or does not act on the application, the applicant may appeal such decision to the State Board of Education (SBE).[375]

Effect of the bill - Developmental Research Laboratory Schools

The bill requires each lab school to develop programs to accelerate the entry of enrolled students into articulated health care programs at its affiliated university or at any public or private postsecondary institution, with the approval of the university president. Additionally, a lab school must offer technical assistance to any Florida school district seeking to replicate the lab school′s programs and must annually report, starting December 1, 2025, to the Legislature on the development of such programs and their results.

Advanced Birth Centers

Licensure

A birth center is any facility, institution, or place in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy, aside from an ambulatory surgical center, hospital, or part of a hospital.[376] Birth centers are licensed and regulated by the Agency for Health Care Administration (AHCA) under ch. 383. F.S., and part II of ch. 408, F.S. Birth centers must have a governing body responsible for the overall operation and maintenance of the birth center.[377] The governing body must develop and provide to all staff, clinicians, consultants, and licensing authorities, a manual that documents the policies, procedures, and protocols of the birth center.[378]

A birth center may accept only those patients who are expected to have normal pregnancies and deliveries. Prior to being accepted for care, the patient must sign an informed consent form.[379] A mother and her infant must be discharged from a birth center within 24 hours after giving birth, except when:[380]

- The mother is in a deep sleep at the end of the 24-hour period, in which case the mother must be discharged as soon after waking as feasible; or
- The 24-hour period is completed during the middle of the night.

If a mother or infant is retained at the birth center for more than 24 hours after birth, for any reason, the birth center must submit a report to AHCA within 48 hours of the birth describing the circumstances and the reasons for the decision.[381]

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[372] Section 1002.32(2), F.S.
[373] *Id.*
[374] Florida State University, The Collegiate School Panama City, https://tcs.fsu.edu/ (last visited January 8, 2024).
[375] Section 1002.33(6)(g), F.S.
[376] Section 383.302(2), F.S.; Section 383.302(8), F.S. defines "low-risk pregnancy" as a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.
[377] Section 383.307, F.S.
[378] *Id.*
[379] Section 383.31, F.S. The informed consent form must advise the patient of the qualifications of the clinical staff, the risks related to out-of-hospital births, the benefits of out-of-hospital births, and the possibility of referral or transfer if complications arise during pregnancy or childbirth with additional costs for services rendered (Rule 59A-11.010, F.A.C.)
[380] Section 383.318(1), F.S., and Rule 59A-11.016(6), F.A.C.
[381] Section 383.318, F.S.

Staff

Birth centers are required to meet certain staffing requirements. Specifically, a birth center must:[382]

- Have at least one clinical staff[383] member for every two clients in labor;
- Have a clinical staff member or qualified personnel[384] available on-site during the entire time a client is in the birth center;
- Ensure that services during labor and delivery are provided by a physician, certified nurse midwife, or licensed midwife, assisted by at least one other staff member, under protocols developed by clinical staff; and
- Have qualified personnel or clinical staff who are able to perform neonatal resuscitation present during each birth.

Additionally, birth centers must ensure that all qualified personnel and clinical staff are trained in infant and adult resuscitation.[385]

Birth centers must have written consultation agreements with each consultant who has agreed to provide advice and services to the birth center.[386] A consultant must be a licensed medical doctor or licensed osteopathic physician who is either certified or eligible for certification by the American Board of Obstetrics and Gynecology, or has hospital obstetrical privileges.[387] Consultation may be provided onsite or by telephone.[388]

Clinical Records

Birth centers are required to maintain a complete clinical record for each client, which must include:[389]

- Identifying information including the client's name, address, and telephone number;
- Initial history and physical examination;
- Obstetrical risk assessments and pre-term labor risk assessments, including the dates of the assessments;
- The date and time of the onset of labor;
- The exact date and time of birth;
- All treatments rendered to the mother and newborn;
- The metabolic screening report;
- Condition of the mother and newborn, including any complications; and
- Referrals for medical care and transfers to hospitals.

Medical Treatments and Procedures

A birth center may perform simple laboratory tests and collect specimens for tests that are requested pursuant to its protocol.[390] A birth center is exempt from the clinical laboratory licensure requirements under ch. 483, F.S., if the birth center employs no more than five physicians and its testing is conducted exclusively in connection with the diagnosis and treatment of patients of the birth center.[391]

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[382] Rule 59A-11.005(3), F.A.C.
[383] Section 383.302(3), F.S., defines "clinical staff" as individuals employed full-time or part-time by a birth center who are licensed or certified to provide care at childbirth.
[384] Rule 59A-11.002(6), F.A.C., defines "qualified staff" as an individual who is trained and competent in the services that he or she provides and is licensed or certified when required by statute or professional standard.
[385] Rule 59A-11.005(3), F.A.C.
[386] Section 383.315(1), F.S.
[387] Section 383.302(4), F.S.
[388] Section 383.315(2), F.S.
[389] Rule 59A-11.005(4), F.A.C.
[390] S. 383.313, F.S.
[391] Id.

Birth centers may perform surgical procedures that are normally performed during uncomplicated childbirths, such as episiotomies and repairs. Birth centers may not perform operative obstetrics or caesarean sections.[392]

Birth centers may not administer general anesthesia or conduction anesthesia. Systemic analgesia and local anesthesia for pudendal block and episiotomy repair may be administered if procedures are outlined by the clinical staff and performed by personnel with statutory authority to do so.[393]
Birth centers may not inhibit, simulate, or augment labor with chemical agents during the first or second stage of labor unless prescribed by personnel with the statutory authority to do so and in connection with and prior to an emergency transport.[394]

Birth centers must provide postpartum care and evaluation that includes physical examination of the infant, metabolic screening tests, referral to pediatric care sources, maternal postpartum assessment, family planning, referral to secondary or tertiary care, and instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.[395]

Physical Plant

Birth centers must be designed to ensure adequate provision for birthing rooms, bath and toilet facilities, storage areas for supplies and equipment, examination areas, and reception or family areas.[396]
Birth centers are required to comply with the provisions of the Florida Building Code and Florida Fire Prevention Code applicable to birth centers.[397] The AHCA may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code that apply to birth centers when conducting inspections.[398]

Equipment

Birth centers must have the equipment necessary to provide low-risk maternity care and readily available equipment to initiate emergency procedures for mothers and infants during life-threatening events.[399] Such equipment must include:

- Oxygen with flow meter and mask or equivalent;
- Resuscitation equipment to include resuscitation bags and oral airways, and laryngoscopes and endotracheal tubes appropriate for the newborn;
- Emergency medications and intravenous fluids with supplies and equipment appropriate for administration;
- Sterile suturing equipment and supplies;
- An examining table and stool;
- An examination light;
- An adult beam scale;
- An infant scale;
- A sphygmomanometer and stethoscope;
- A clinical thermometer;

[392] Id.
[393] Id.
[394] Id.
[395] Section 383.318, F.S.
[396] Section 383.308(1), F.S.
[397] Section 383.309(2), F.S.; Section 452 of the Florida Building Code provides requirements for birth centers.
[398] Id.
[399] Section 383.308(2)(a), F.S.

- A fetoscope or doppler unit;
- A bassinet;
- A sweep second hand clock;
- A mechanical suction or bulb suction; and
- A firm surface suitable for resuscitation.

Penalties and Fines

AHCA may impose an administrative fine not to exceed $500 per violation per day for the violation of any provision of the Birth Center Licensure Act, part II of chapter 408, or applicable rules.[400] AHCA may also impose an immediate moratorium on elective admissions to any birth center when it determines that any condition in the facility presents a threat to the public health or safety.[401]

Annual Report

Birth centers are required to submit an annual report to AHCA that details, among other things:[402]
- The number of deliveries by birth weight;
- The number of maternity clients accepted for care and length of stay;
- The number of surgical procedures performed at the birth center by type;
- Maternal transfers, including the reasons for each transfer and whether it occurred intrapartum or postpartum, and the length of the subsequent hospital stay;
- Newborn transfers, including the reasons for each transfer, the birth weight, days in hospital, and Apgar score at five and ten minutes;[403]
- Newborn deaths;
- Stillborn/fetal deaths; and
- Maternal deaths.

Effect of the bill - Advanced Birth Centers

Licensure

The bill creates a new designation for birth centers as advanced birth centers (ABCs), and allows ABCs to treat more types of patients and perform more types of procedures than traditional birth centers. The bill authorizes ABCs to perform trial of labor after cesarean deliveries for screened patients who qualify, planned low-risk cesarean deliveries, and anticipated vaginal deliveries for laboring patients from the beginning of the 37th week of gestation through the end of the 41st week of gestation.

To be designated as an ABC, a birth center must maintain all the statutory requirements for both birth centers and advanced birth centers and:
- Meet all standards adopted by rule for birth centers, unless specified otherwise.
- Comply with the Florida Building Code and Florida Fire Prevention Code standards for ambulatory surgical centers.
- Be operated and staffed 24 hours per day, 7 days per week.

[400] S. 383.33, F.S.
[401] Id.
[402] Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Feb. 2015).
[403] Apgar is a quick test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score tells the health care provider how well the baby is doing outside the mother's womb. In rare cases, the test will be done 10 minutes after birth. See *Apgar Score*, Medline Plus, *available at* https://medlineplus.gov/ency/article/003402.htm (last visited January 8, 2024).

- Employ two medical directors to oversee the activities of the center, one of whom must be a board-certified obstetrician and one of whom must be a board-certified anesthesiologist, both licensed under either ch. 458 or 459, F.S.
- Employ at least one registered nurse and ensure that at least one registered nurse is present in the center at all times and has the ability to stabilize and facilitate the transfer of patients and newborn infants when appropriate.
- Have at least one properly equipped, dedicated surgical suite for the performance of cesarean deliveries.
- Enter into a written agreement with a blood bank for emergency blood bank services and have written protocols for the management of obstetrical hemorrhage which include provisions for emergency blood transfusions.
- Qualify for, enter into, and maintain a Medicaid provider agreement with AHCA pursuant to s. 409.907, F.S., and provide services to Medicaid recipients according to the terms of the provider agreement.

The bill requires AHCA to establish a procedure for designating birth centers as ABCs. Standards adopted for such designation must be, at a minimum, equivalent to the minimum standards for ASCs and include standards for quality of care, blood transfusions, and sanitary conditions for food handling and food service.

The bill creates s. 383.3131, F.S., to establish separate requirements for ABCs related to laboratory services, surgical services, administration of analgesia and anesthesia, and intrapartal use of chemical agents.

Medical Treatments and Procedures

ABCs must have an onsite clinical laboratory which is, at a minimum, capable of testing for hematology, metabolic screening, liver function, and coagulation studies. The ABC is authorized to collect specimens for those tests that are requested under protocol and may perform any tests authorized by AHCA in rule. Laboratories in ABCs must be appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

In addition to the surgical services a birth center may perform, the bill authorizes an ABC to perform surgical procedures for low-risk cesarean deliveries and surgical management of immediate complications. Additionally, an ABC may perform post-partum sterilization before the discharge of a patient who has given birth during her admission and may perform circumcisions before discharging newborn infants.

The bill authorizes an ABC to administer general, conduction, and local anesthesia if administered by personnel who have statutory authority to do so. All anesthesia must be administered by an anesthesiologist or certified registered nurse anesthetist (CRNA). If general anesthesia is administered, a physician or CRNA must be present in the ABC during the anesthesia and the post anesthesia recovery period until the patient is fully alert.

The bill authorizes the use of chemical agents to inhibit, stimulate, or augment labor during the first or second stage of labor at an ABC if prescribed by personnel who have the statutory authority to do so. Labor may be induced at the 39th week of gestation for a patient with a document Bishop score of eight or greater.[404]

[404] The Bishop scoring system is based on a digital cervical exam of a patient with a zero point minimum and 13 point maximum. The scoring system utilizes cervical dilation, position, effacement, consistency of the cervix, and fetal station. A Bishop score of 8 or greater is considered to be favorable for induction, or the chance of a vaginal delivery with induction is similar to spontaneous labor. A score of 6 or less is considered to be unfavorable if an induction is indicated cervical ripening agents may be utilized. See Wormer KC, Bauer A,

The bill requires ABCs to employ or maintain an agreement with an obstetrician who must be on call at all times during which a patient is in active labor in the center in order to attend deliveries, respond to emergencies, and, when necessary, perform cesarean deliveries. ABCs are also required to enter into a written transfer agreement with a local hospital for the transfer and admission of emergency patients or have a written agreement with an obstetrician who has hospital privileges and who has agreed to accept the transfer of the ABCs patients.

The bill allows an ABC to keep a mother and infant in the ABC for up to 48 hours after a vaginal delivery or up to 72 hours after a cesarean delivery, except in unusual circumstances as defined in rule by AHCA. If a mother or infant is retained longer than the allowed time, a report must be filed with AHCA within 48 hours of the scheduled discharge time which must describe the circumstances and reasons for keep the patient.

Health Care Spending

Health spending in the United States has exploded in the last 50 years, totaling $74.1 billion in 1970, increasing to $1.4 trillion by 2000, then tripling in 2021 to $4.3 trillion.[405] Total national health expenditures grew by $175 billion in 2022 from 2021 with hospital expenditures and retail prescription drugs accounting for approximately one-third of the spending growth.[406]

Private insurance expenditures have also been growing at a faster pace than either Medicaid or Medicare spending. In 1970, private health insurance expenditures represented 20.4 percent of total health spending; whereas, for 2022, the percentage had grown to 28.9 percent.[407] Additionally, per enrollee spending by private insurers increased by 61.6 percent from 2008 to 2022, a rate that was faster than the per enrollee spending for public programs such as Medicare and Medicaid. From 2021 to 2022, the rate for private insurers was 4.3 percent while Medicaid rose by 2.2 percent and Medicare by 3.8 percent.[408]

The following chart illustrates the rate of growth in total national health expenditures from 1970 to 2022[409]:

Williford AE. Bishop Score. [Updated 2023 Sep 4]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available at https://www.ncbi.nlm.nih.gov/books/NBK470368/, (last visited January 8, 2024).

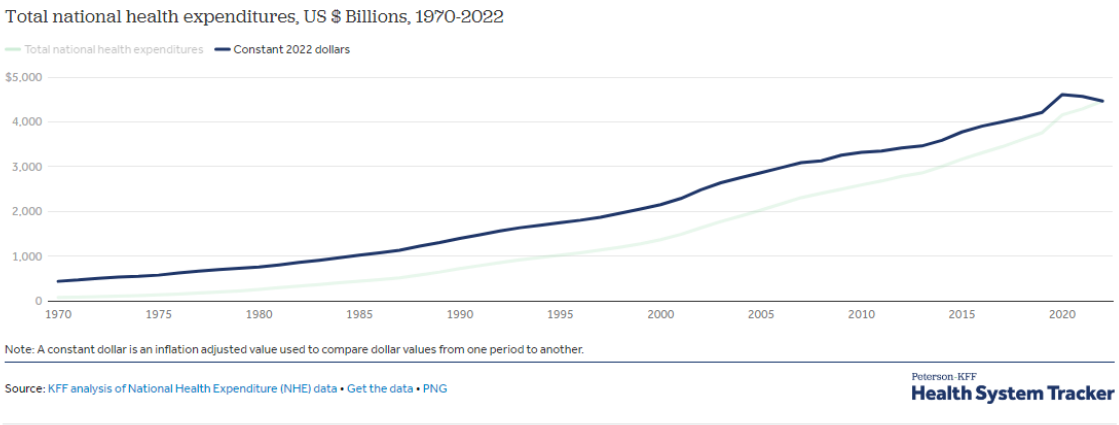
[405] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How has U.S. spending on healthcare changed over time?*, December 15, 2023, available at https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20Billions,%201970-2022 https://healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/ (last viewed on January 3, 2024).

[406] *Id.*

[407] *Id.*

[408] *Id.*

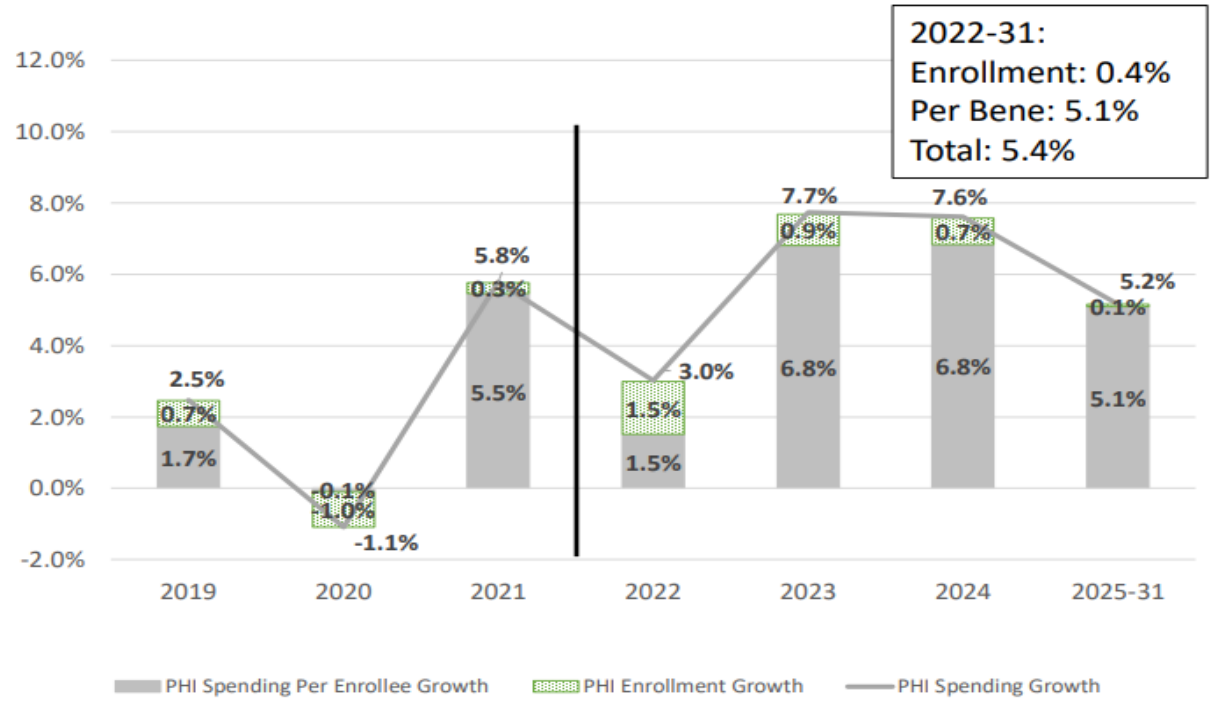
[409] *Supra*, note 405.



Health care prices are a primary driver of health care spending. While health care spending has slowed in recent decades, from a high of 12 percent in the 1970s to the current 9.6 percent for the 2020-2022 period, spending still consistently exceeds growth in the country's GDP.[410] Per enrollee spending for those with private health insurance in 2023 to 2024 is expected to be at a faster pace than in 2022 due to an increase in health care utilization and health care costs. Growth in the private health insurance market, according to the Chief Actuary's report,[411] is tied to increased enrollment in the Marketplace while additional subsidies were available under the American Rescue Plan Act.[412]

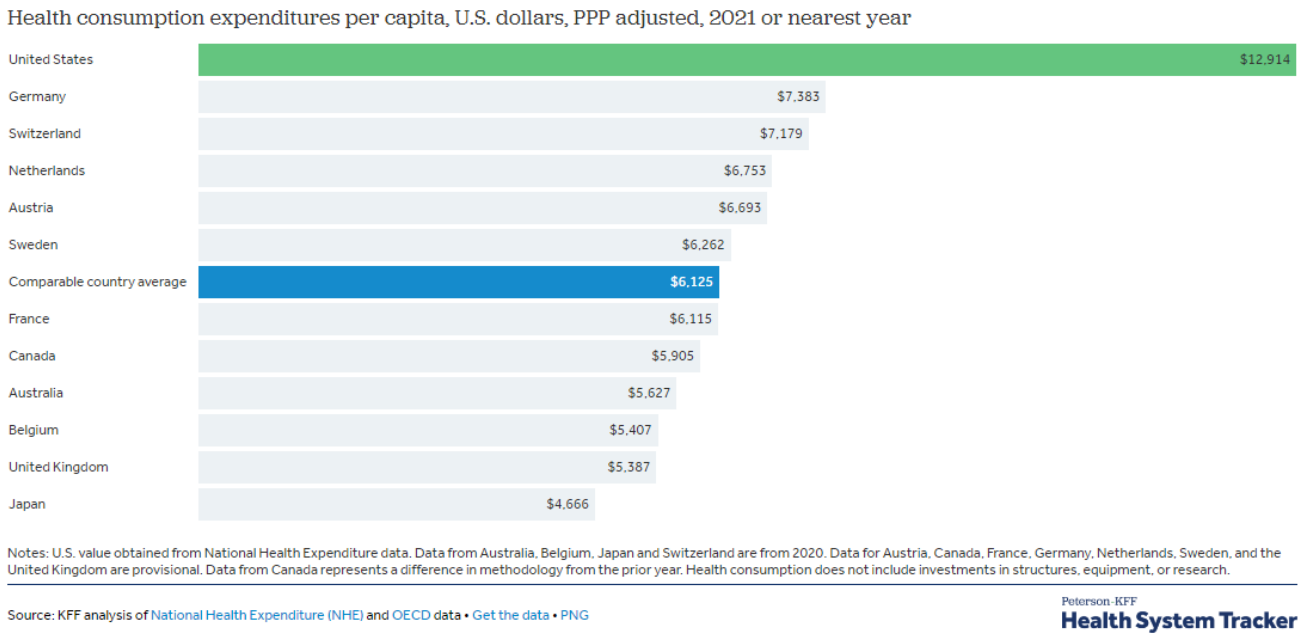
Projections for 2022-31 by the Office of the Actuary at Centers for Medicare and Medicaid Services show an average predicted growth rate in national health expenditures (NHE) of 5.4 percent which would outpace the expected average GDP growth rate for the same time period of 4.6 percent.[413] The chart below illustrates the average annual growth in enrollment per beneficiary spending, and total spending, by the designated time period.[414] The reductions shown for the outlier years of 2025 through 2031 are tied to the expiration of the Marketplace subsidies which exist in current law and the associated projected 10 percent or 2 million beneficiaries drop in privately purchased health insurance coverage.[415]

[410] *Supra*, note 405
[411] Centers for Medicare and Medicaid Services, *National Health Expenditures Projections 2022-31: Growth to Stabilize Once Public Health Emergency Ends*, June 14, 2023, Slide 10, available at *https://www.cms.gov/files/document/release-presentation-slides-national-health-expenditure-projections-2022-31-growth-stabilize-once.pdf* (last visited January 3, 2024).
[412] *Id*. The American Rescue Plan Act of 2021 (P.L. 117-7) amended the Patient Protection and Affordable Care Ac (P.L. 111-148, March 28, 2010 and Health Care and Education Reconciliation Act of 2010 ((P.L. 2010 -152, March 30, 2010)), collectively known as PPACA) to provide additional funding relief to the states to address a range of impacts from the COVID-19 pandemic. Included in its provisions, was a special rule for any individual who had received or had been approved to receive unemployment compensation during 2021 for the plan year in which the compensation began which qualified any such individual for the same cost sharing subsidies for health care expenses under qualified health insurance plans in the Marketplace as any other individual in a household income of 133 percent of the poverty or less for the family size involved. The special rule was effective with plan years which began after December 31, 2020. (Section 2305 of H.R. 1319; March 11, 2021).
[413] *Supra* note, 411
[414] *Id.*



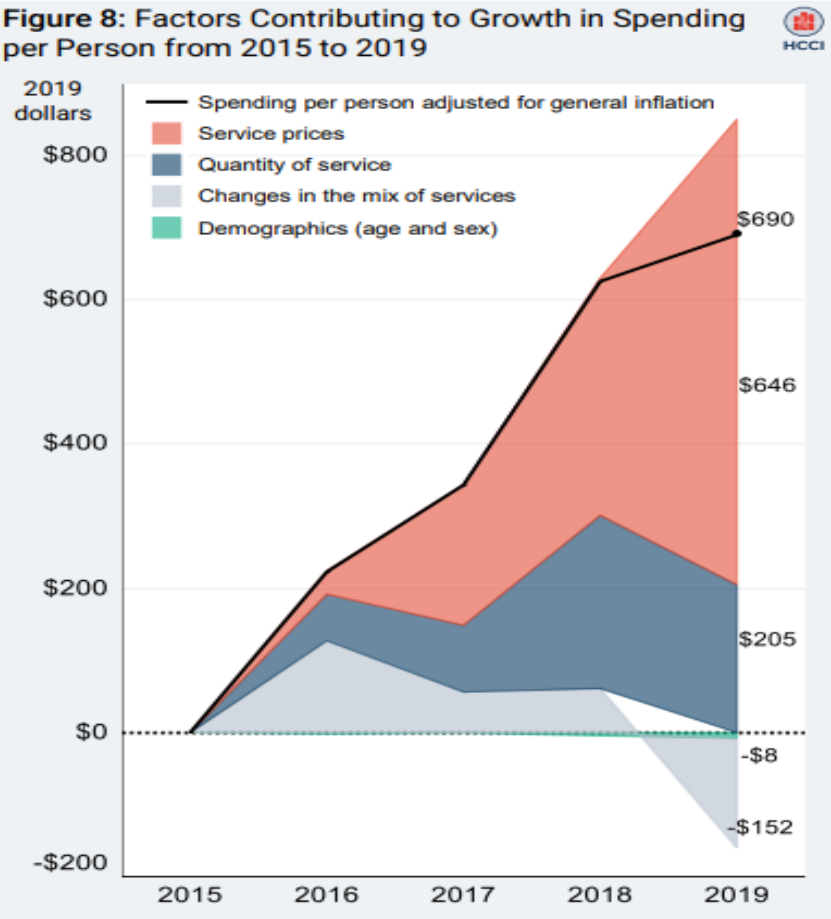
NOTE: Average annual growth rates are from previous year shown.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

The United States spends more per person on health care than any other high-income country in the world and spending has continued to increase over the past few decades. Health spending per person in the U.S. was $12,914 in 2021 and increased for 2022 to $13,493, more than $5,000 greater than any other high income nation.[416]



[416] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How does health spending in the U.S. compare to other countries?*, February 9, 2023, available at (https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ last viewed on January 3, 2024). The average amount spent on health per person in comparable countries – $6,125 – is less than half of what the U.S. spends.

The Organization for Economic Cooperation Development estimated that total spending in 2019 in its member countries averaged 8.8 percent of GDP, compared with 16.8 percent in the U.S.[417] One study found that United States commercial health spending per enrollee increased by 21.8% between 2015 and 2019.[418] The rising prices of health care services accounted for approximately two-thirds of that growth, with prices for prescription drugs, provider services (physical examinations, screenings and procedures) and inpatient and outpatient care rising by 18.3%.[419] The following chart details the factors contributing to the growth in spending, per capita, in the United States:[420]



Health Care Price Transparency

This country is experiencing significant changes in the payment and delivery of health care services. Consumers bear a greater share of health care costs, and more consumers participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs, and insurance coverage.

[417] *Supra*, note 405.
[418] Health Care Cost Institute, *2019 Health Care Cost and Utilization Report*, pg. 2, available at https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf (last viewed January 3, 2024).
[419] *Id.*
[420] *Supra*, note 405

Price transparency can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[421] Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and, identifies a consumer's out-of-pocket cost.[422] Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."[423] Indeed, the definition of the price or cost of health care has different meanings depending on who is incurring the cost.[424]

Employee Out of Pocket Costs

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the *2023 Kaiser Family Foundation Employer Health Benefits Survey*, 30 percent of Americans with private insurance were enrolled in a HDHP in 2023.[425] Additionally, employees in most firms, 77 percent, do not have a choice of health plans or benefit options, including 26 percent who are in firms where the only offer is a high deductible plan with savings option (HDHP/SO).

Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. For 2023, ninety percent of covered workers had a general annual deductible[426] for single coverage that must be met before most services are paid for by their health plan.[427] Ten years ago, the percentage of covered workers with a general annual deductible was 78 percent and 85 percent five years ago.[428]

Among covered workers with a general annual deductible, the 2023 average deductible amount for single coverage across all plan types is $1,735 which is similar to the average amount for 2022 of $1,763.[429] Deductibles can differ greatly by a number of factors, including firm size, region, or whether a plan incorporates other cost sharing provisions. Looking at costs by firm size in 2023; the average amount for single coverage was $2,434 in small firms and $1,478 in large firms.[430]

The 2023 plan deductible averages reflect moderate reductions from the average deductibles for small and large group plans in 2022 which were $2,543 and $1,493, respectively. Seventy-four percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 58 percent in large firms;[431] a similar pattern exists for those in plans with a deductible of at least $2,000 (47 percent for small firms vs. 25 percent for large firms). The chart below shows the

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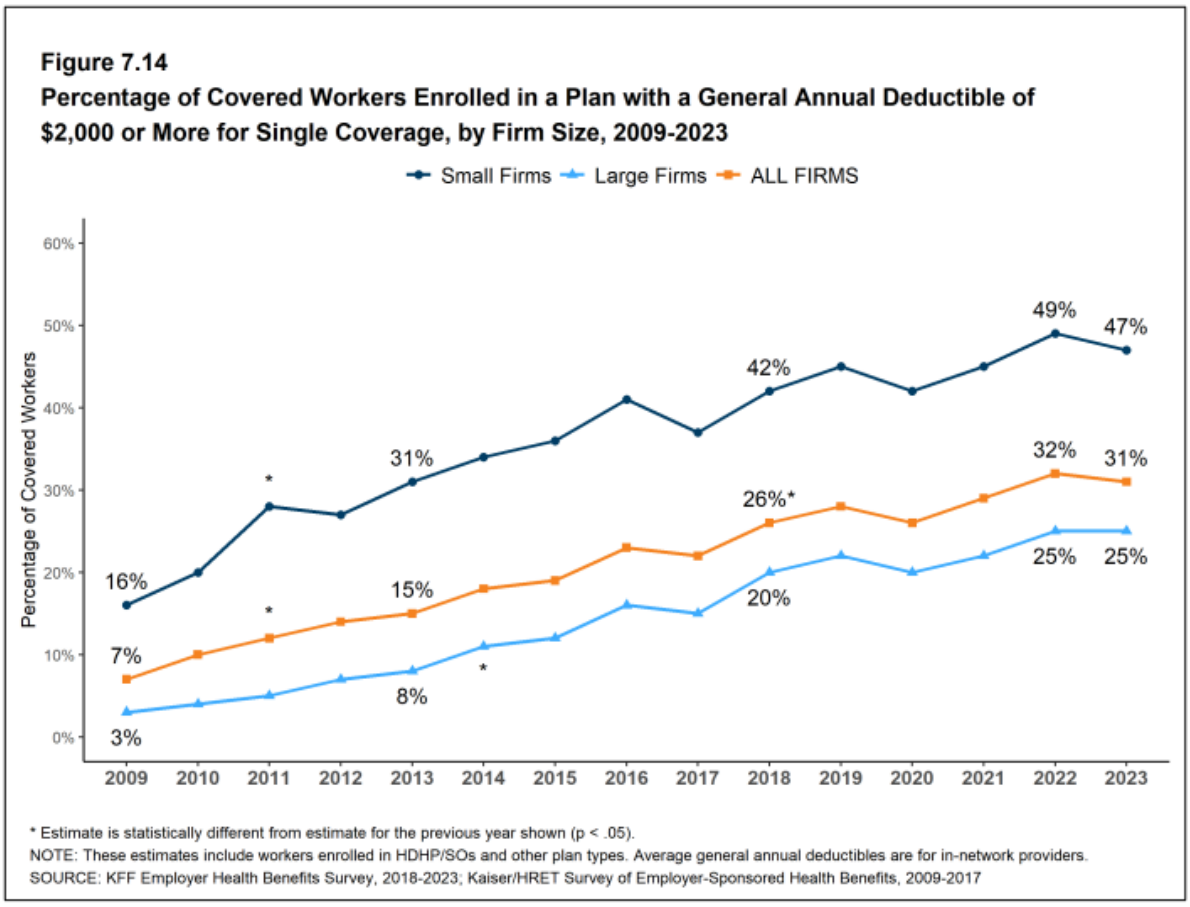
[421] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, pg. 2, available at https://www.gao.gov/products/gao-11-791 (last viewed January 3, 2024).
[422] *Id.*
[423] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, pg. 2, April 10, 2014 available at https://www.hfma.org/payment-reimbursement-and-managed-care/pricing/22274/ (last viewed January 5, 2024).
[424] *Id.*
[425] The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey,* October 18, 2023, p. 79, available at https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (last viewed on January 3, 2024).
[426] The term "general annual deductible" means a deductible which applies to both medical and pharmaceutical benefits and which must be met by the insured individual before most services are covered by the health plan. *See* The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey,* October 18, 2023, p. 106, available at https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (last viewed on January 3, 2024).
[427] *Id.*
[428] *Id.*, and FIG. 7.2 at p.108.
[429] *Id.*
[430] *Id.* at 107-108.
[431] *Id.* at 115 and FIG. 7.13.

percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2009 through 2023.[432]



From 2013 to 2023, the average premium contribution required of covered workers with family coverage increased 19 percent and if broken down by just the last 5 years, the average worker contribution towards family health insurance coverage has increased by 22 percent compared to a 27 percent in workers' wages and 21 percent inflation.[433] The dramatic increases in the costs of health care in recent years have focused significant attention on the need for greater communication and transparency to inform individual health care choices.

Employer contributions to coverage vary widely based on the type of coverage and plan. For small plans, 30 percent of employers pay the entire premium for individual coverage of their workers whereas this is only the case with 6 percent of large firm employers. For family coverage, however, only small firm employees contribute more than half the premium costs for family coverage, compared to 8 percent of covered workers in large firms.[434]

For workers in high deductible health plan plans (HDHP), they may receive contributions from their employer into a savings account which may be used to reduce cost sharing amounts or to cover items not included in the employer's benefit package. In 2023, 7 percent of covered workers with a HDHP with a health reimbursement arrangement (HRA)[435] and 4 percent of covered workers in a Health

[432] *Id*., at116 and FIG.7.14.
[433] *Id*. at 7.
[434] *Id*. at 9.
[435] A high deductible health plan with a savings option (HDHP/SOs) are health plans which have a deductible of at least $1,000 for individual coverage and $2,000 for family coverage which are paired with a health reimbursement account (HRA), or a high deductible health plan that is considered by federal requirements to be a qualified HDHP. Funds in these savings accounts are pre-tax dollars which may be used to cover out-of-pocket medical expenses and other plan cost sharing.

Savings Account (HSA) – qualified HDHP received an employer contribution to their accounts that was greater than or equal to their annual deductible.[436] An HRA is defined by the Internal Revenue Service (IRS) as an account-based group health plan provided by an employer to provide for the reimbursement of medical expenses under IRS Code section 213(d) and is subject to maximum, fixed-dollar amounts for reimbursements within a specified period, usually a plan year.[437]

For those employees with an HDHP with an HRA, 12 percent of those workers received an employer contribution that if the amount had been applied to the worker's annual deductible, the remaining deductible would be less than $1,000.[438] HSA-qualified HDHPs are required by federal law to have an annual out of pocket maximum of no more than $7,500 for single coverage and $15,000 for family coverage. For HDPS with an HRA option that are not grandfathered plans, the out of pocket maximum in 2023 was $9,100 for single coverage and $18,200 for family coverage. The average out of pocket maximum for 2023 was $5,456 for HDHP/HRAs and $4,415 for HSA-qualified HDHPs.[439]

Such funding arrangements are more likely to be found in firms with more than 200 workers (57 percent) than smaller firms (29 percent).[440] Enrollment has increased over the past 10 years in HDP/SOs growing from 10 percent of covered workers in 2013 to 29 percent in 2023.[441]

National Price Transparency Studies

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending." As noted by the authors, American consumers have historically found it difficult to comparison shop for health care services as information about pricing and service delivery is buried in secrecy and shrouded in medical jargon once information is uncovered by the consumer.[442] The authors also provide a two-step definition of price transparency: A process which, first, more generally describes price transparency as the readily available price data for the purposes of price comparison, and a second which focuses on different audiences who use that data and the unique needs of those different audiences.[443]

This report, conducted in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save $100 billion over ten years.

- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- Expand state-based all-payer health claims databases, which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[444]

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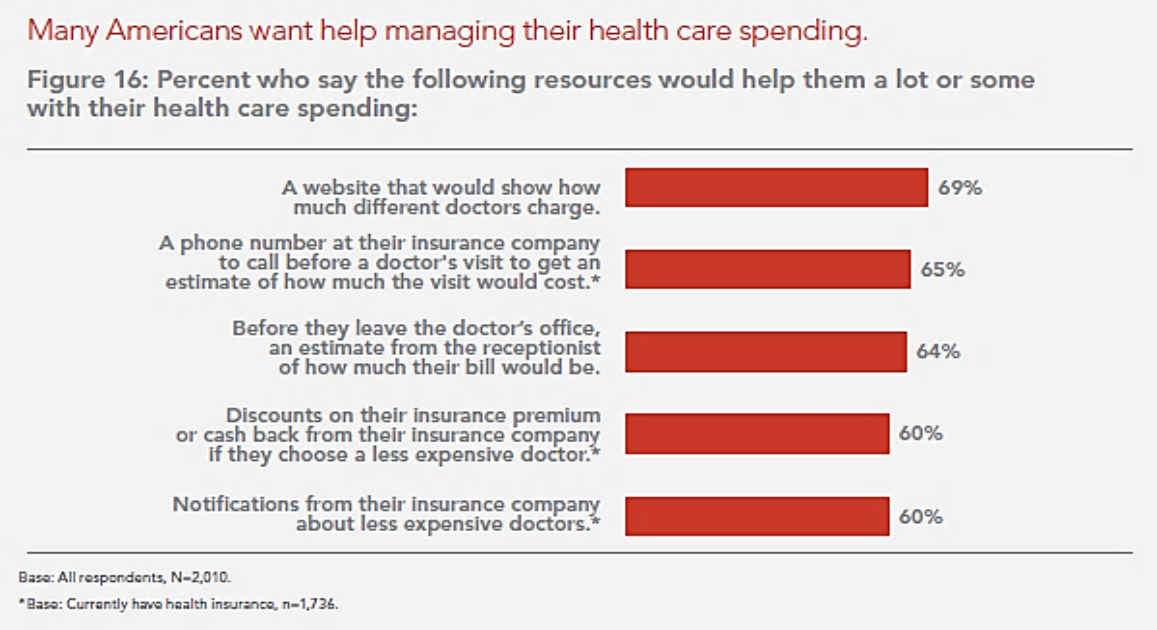
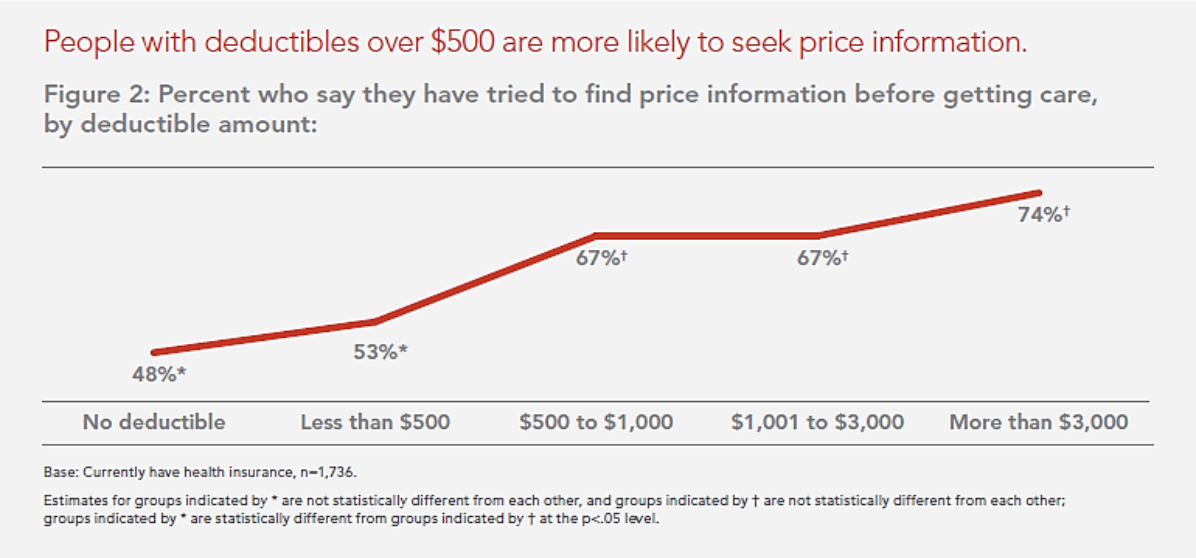
[436] *Supra*, note 426 at 12.
[437] *Health Reimbursement Arrangements and Other Account Based Group Health Plans*, Supplementary Information – Final Rule, 84 Fed.Reg.119, 28887 (June 20, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf (last viewed January 4, 2024).
[438] *Supra*, note 426 at 12.
[439] *Supra*, note 426 at 147.
[440] *Supra*, note 426 at 140.
[441] *Supra*, note 426 at 142.
[442] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, p. 3, available at https://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf (last viewed January 4, 2024) .
[443] *Id.*
[444] *Id.*

The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[445]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[446]



One study in 2014, which included a survey of more than 2,000 adults from across the country, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[447] The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[448]



[445] *Id.,* at. 1.
[446] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/reports/how-much-will-it-cost-how-americans-use-prices-in-health-care/ (last viewed January 5, 2024).
[447] *Id.*, at 3.
[448] *Id.*, pg. 13.

The individuals who compared prices stated that such research affected their health care choices and saved them money.[449] In addition, the study found that most Americans do not equate price with quality of care. Seventy-one percent do not believe higher price reflects higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[450] Consumers enrolled in high-deductible and consumer-directed health plans are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. Accordingly, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.[451] Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.[452]

Florida Price Transparency: Florida Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[453] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[454] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

A patient has the right to request certain financial information from health care providers and facilities.[455] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[456] Estimates must be written in language "comprehensible to an ordinary layperson."[457] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[458] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[459]

Currently, under the Patient's Bill of Rights financial information and disclosure provisions:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full

[449] *Id*., pg. 4.
[450] Supra, FN 14.
[451] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, pg. 4, available at https://www.air.org/sites/default/files/Resource-rwjf402126.pdf (air.org)(last viewed January 4, 2024).
[452] Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, Health Affairs 2012; 31(3): 560-568 ,available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.1168 (last viewed on January 5, 2024).
[453] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[454] S. 381.026(3), F.S.
[455] S. 381.026(4)(c), F.S.
[456] S. 381.026(4)(c)3., F.S.
[457] *Id*.
[458] *Id*.
[459] S. 381.026(4)(c)5., F.S.

payment for medical services and treatment rendered in the provider's office or health care facility.

- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient's Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the website of the Agency for Health Care Administration (AHCA).
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[460]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[461] to publish a schedule of charges for the medical services offered to patients.[462] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[463] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[464] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.[465]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[466] This applies to any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures; and licensed health care clinics that operate in three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.[467] The schedule must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day (until the schedule is published and posted).[468]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[469] must provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the

[460] S. 381.0261, F.S.
[461] S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[462] S. 381.026(4)(c)3., F.S.
[463] *Id.*
[464] *Id*.
[465] S. 381.026(4)(c)4., F.S.
[466] S. 395.107(1), F.S.
[467] S. 395.107(2), F.S.
[468] S. 395.107(6), F.S.
[469] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.

average charges for that diagnosis related group[470] or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law also directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided.[471] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[472] Hospitals and other facilities post a link to this site - https://pricing.floridahealthfinder.gov/ - to comply with the price transparency requirements. The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[473]

The law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.[474]

Federal Price Transparency Laws and Regulations

Congress and federal regulatory agencies recently took steps to improve the quantity and quality of health care cost information available to patients.

Hospital Facility Transparency

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[475] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file of standard

[470] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention and resource intensity. For more information, see https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last viewed January 6, 2024).
[471] S. 395.301, F.S.
[472] S. 408.05(3)(c), F.S.
[473] *Id.*
[474] S. 456.0575(2), F.S.
[475] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 FR 65524 (November 27, 2019)(codified at 45 CFR Part 180).

charges and a consumer-friendly presentation of prices for at least 300 shoppable health care services. The regulations became effective on January 1, 2021.[476]

The regulations define a shoppable service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This information should provide a patient with both a reasonable point estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall.

The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[477] Very early indications suggest that there are varying levels of compliance with the new rules among hospital facilities.[478]

Health Insurer Transparency

On October 29, 2020, the federal Departments of Health and Human Services, Labor, and Treasury finalized regulations[479] imposing new transparency requirements on issuers of individual and group health insurance plans.

Estimates

Central to the new regulations is a requirement for health plans to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurance plans must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs *before* receiving health care to encourage shopping and price competition amongst providers.[480]

Each health plan will be required to establish an online shopping tool that will allow insureds to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services. This requirement is scheduled to take effect on January 1, 2023. Beginning in 2024, health plans will need to provide personalized cost-sharing information to patients across the full range of covered health care services.[481]

Medical Loss Ratio

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[476] *Id.*
[477] *Supra*, note 445.
[478] ADVI, "*Implementation of Newly Enacted Hospital Price Transparency*," available at https://advi.com/analysis/Hospital_Transparency_-_ADVI_Summary.pdf.
[479] Transparency in Coverage, 85 FR 73158 (November 12, 2020)(codified at 29 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147, and 45 CFR Part 158).
[480] Trump Administration Finalizes Transparency Rule for Health Insurers," Health Affairs Blog, November 1, 2020. Available at https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last viewed on January 6, 2024).
[481] *Supra*, note 72.

The regulations also clarify the treatment of shared savings expenses under medical loss ratio (MLR) calculations required by the Patient Protection and Affordable Care Act (PPACA). MLR refers to the percentage of insurance premium payments that are actually spent on medical claims by an insurer. In general, MLR requirements are intended to promote efficiency among insurers.[482] The PPACA established minimum MLR requirements for group and individual health insurance plans.[483] Under the PPACA, large group plans must dedicate at least 85 percent of premium payments to medical claims, while small group and individual market plans must dedicate at least 80 percent of premium payments to medical claims.[484] Further, the law requires a health plan that does not meet these standards to provide annual rebates to individuals enrolled in the plan.[485]

The regulations finalized in October 2020 specify that expenses by a health plan in direct support of a shared savings program shall be counted as medical expenditures.[486] Thus, a health plan providing shared savings to members will receive an equivalent credit towards meeting the MLR standards established by PPACA. In theory, this policy should provide an additional incentive for insurers who have not already done so to adopt shared savings programs.

The Federal No Surprises Act

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[487] The No Surprises Act includes a wide-range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of care. Most sections of the Act went into effect on January 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor were tasked with issuing regulations and guidance to implement a number of the provisions.[488]

Estimates – Facilities

In the realm of price transparency, the No Surprises Act establishes the concept of an "advanced explanation of benefits" that combines information on charges provided by a hospital facility with patient-specific cost information supplied by a health insurance plan. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a "good faith estimate" of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured).[489]

Estimates – Health Plans

Once the "good faith estimate" has been shared with a patient's health plan, the plan must then develop a more detailed and "advanced explanation of benefits". This personalized cost estimate must include the following:

- An indication of whether the facility participates in the patient's health plan network. If the facility is non-participating, information on how the patient can receive services from a participating provider;
- The good-faith estimate prepared by the hospital facility based on billing/diagnostic codes;
- A good-faith estimate of the amount to be covered by the health plan;

[482] "Explaining Health Care Reform: Medical Loss Ratio (MLR)", Henry J Kaiser Family Foundation, February 29, 2012. Available at https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (last viewed on January 5, 2024).
[483] PPACA s. 1001; 42 U.S.C. 300gg-18.
[484] *Supra*, note 475.
[485] *Id.*
[486] 45 CFR Part 158.
[487] PL 116-260. The No Surprises Act is found in Division BB of the Act.
[488] *Id.*
[489] PL 116-260, Division BB, Section 112.

- A good-faith estimate of the amount of the patient's out-of-pocket costs;
- A good-faith estimate of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's health plan;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (i.e., medical necessity determinations, prior authorization, step therapy, etc.); and,
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.[490]

Furthermore, the Act directs the Secretary of Health and Human Services (HHS) to establish by January 1, 2022, a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals that substantially differ from a provider's good faith estimate provided prior to the service being rendered.[491]

The new requirements placed on hospitals and health plans by the No Surprises Act are cumulatively intended to provide patients with increased certainty about the total and out-of-pocket costs associated with health care services. In turn, patients may be more equipped to seek out cost-effective care and avoid unforeseen costs that can lead to financial strain,
Many hospitals currently do not comply with the federal transparency requirements. A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.[492] Further, an August 2022 review of 2,000 hospitals found that 16 percent complied with all transparency requirements.[493] Nearly 84 percent of hospitals failed to post machine-readable files containing standard charges, and roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.[494] Another review of more than 6,400 hospitals showed wide-spread non-compliance with the federal transparency rule- more than 63 percent of hospitals were not in compliance as of the report date.[495] According to that same review, only 38 percent of Florida hospitals were in compliance.[496] The first fines were not levied by federal CMS against Northside until almost 18 months after the rule's effective date and even when levied, the total amount of those fines were less than 0.1 percent of Northside Hospital system's total gross revenues[497].

Medical Debt

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. Nationwide, over 100 million have some form of medical debt.[498] A 2007 study suggested that illness and medical bills contributed to 62.1 percent of all personal bankruptcies filed in the United States during that year.[499] A more recent analysis, which considered only the impact of hospital charges, found that 4 percent of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[500]

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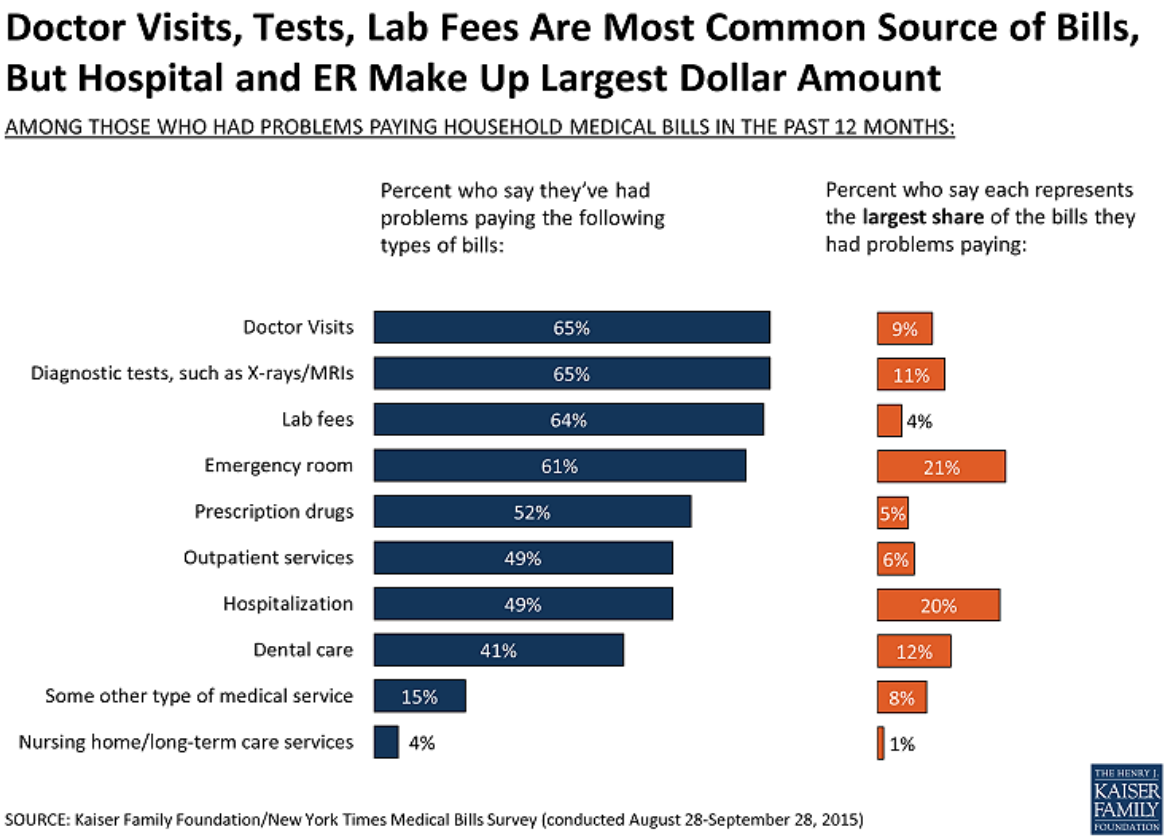
[490] PL 116-260, Division BB, Section 111.
[491] Supra, FN 80.
[492] John Xuefeng Jiang, et al., *Factors associated with compliance to the hospital price transparency final rule: A national landscape study*, Journal of General Internal Medicine (2021), available at https://link.springer.com/article/10.1007/s11606-021-07237-y (last viewed on January 4, 2024).
[493] Patients' Rights Advocates, *Third semi-annual hospital transparency compliance report, 2022*, available at https://www,patientrightsadvocates.org/august-semi-annual-compliance-report-2022 (last reviewed January 5, 2024)..
[494] *Id.*
[495] Foundation for Government Accountability, *How America's Hospitals Are Hiding the Cost of Health Care*, pg. 3, August 2022, available at https://www.TheFGA.org/paper/americas-hospitals-are-hiding-the-cost-of-health-care. (last viewed on January 4, 2024). As of the date of the report, only two hospitals to date had been fined for noncompliance with the transparency rule, both of which were in Georgia's Northside Hospital System.
[496] *Id*. at 4.
[497] *Id*. at 4.
[498] Kaiser Health News, *Diagnosis: Debt – 100 Million People in America Are Saddled with Health Care Debt*, June 16, 2022, available at https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/ (last viewed on January 4, 2024).
[499] David U. Himmelstein, et al. *"Medical Bankruptcy in the United States, 2007: Results of a National Study." American Journal of Medicine* 2009; 122: 741-6. available at https://www.amjmed.com/article/S0002-9343(09)00404-5/abstract.
[500] Carlos Dobkin, et al. *"Myth and Measurement: The Case of Medical Bankruptcies." New England Journal of Medicine* 2018; 378:1076-1078. Available at https://www.nejm.org/doi/full/10.1056/NEJMp1716604.

Four in ten U.S. adults have some form of health care debt,[501] including one in 8 people who reported health care debts of at least $10,000 or more in a 2022 Kaiser Family Foundation poll.[502]

About half of adults – including three in ten who do not currently have health care debt – are vulnerable to falling in the debt, saying they would be unable to pay a $500 unexpected medical bill without borrowing money.[503] While about a third of adults with health care debt owe less than $1,000, even small amounts of debt can have significant financial consequences for some.[504] Though a third of those with current debt expect to pay it off within a year and about a quarter expect to pay it within one to two years, nearly one in five adults with health care debt think they will never be able to pay it off.[505]



Even when medical costs do not result in personal bankruptcy, they often weigh heavily on the financial health of patients and their families. According to the Kaiser Family Foundation, about a quarter of U.S. adults ages 18-64 say they or someone in their household had problems paying or having an inability to pay medical bills in the past 12 months.[506] About three in ten survey respondents reported medical debt of $5,000 or more, with 13 percent of respondents indicating medical debt in excess of $10,000. Even patients with lower amounts of medical debt reported that the outstanding bills led to financial distress, in light of other financial commitments and/or limited income.[507]

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[501] Lopes, L., Kearney, A., et al, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, June 16, 2022 (using results from the Kaiser Family Foundation Health Care Debt Survey), available at https://www.kff.org/health-costs/report/kff-health-care-debt-survey/ (last viewed on January 5, 2024).
[502] *Id.*
[503] *Id.*
[504] *Id.*
[505] *Id.*
[506] The Henry J. Kaiser Family Foundation, *"The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey."* January 5, 2016, available at https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/(last viewed on January 5, 2024)
[507] *Id.*a

Among those who reported problems paying medical bills, 66 percent said the bills were the result of a one-time or short-term medical expense such as a hospital stay or an accident, while 33 percent cited bills for treatment of chronic conditions that had accumulated over time. Respondents to the Kaiser survey reported a wide range of illnesses and injuries that led to an accumulation of medical debt. The largest share (36 percent) named a specific disease, symptom, or condition like heart disease or gastrointestinal problems, followed by issues related to chronic pain or injuries (16 percent), accidents and broken bones (15 percent), surgery (10 percent), dental issues (10 percent), and infections like pneumonia and flu (9 percent).[508]

More than two thirds of hospitals sue or take other legal action against patients with outstanding bills. Nearly 25 percent sell patient medical debt to collection agencies, who in turn can pursue patients for years to collect on unpaid bills. Further, one in five providers deny nonemergency care to people with outstanding medical debt.

Further polling results contained in the 2022 Kaiser report also showed that families who had experienced medical debt problems were also more likely to ask about the cost of a medical service or doctor's office visit beforehand than someone who had not had such difficulties (49 percent compared to 34 percent). Such families were also much more likely to shop around for services for the best price (34 percent compared to 17 percent) and to attempt to negotiate a lower rate before receiving a health care service (22 percent compared to six percent). Impacted families with medical debt also reported a higher rate of being asked to pay for health care services up front before services would be delivered.[509]

Personal Credit Ratings

Recognizing the inherent difficulties associated with medical debt, the three major credit rating companies in July 2023 agreed to exclude from an individual's credit report medical debts that have been paid off and unpaid medical debts less than $500. This action followed a 2015 settlement agreement with several state Attorney Generals which had established a minimum time period of 180 days before a medical debt could be report to a credit agency.[510] The national credit reporting companies announced that this time period would be expanded voluntarily to one year in 2022.

With the 2023 agreement and the $500 capped medical debt collection, regulators expect that the majority of medical debt will fall under this dollar threshold, although geographic differences in the average amount of medical debt across the county exist as do higher amounts in neighborhoods that are majority Black or Hispanic and have lower median incomes.[511]

When a person first takes out a line of credit as an individual—a first credit card or a loan to pay for college, for example—this begins a personal credit history and the process of building a personal credit score. This score is linked to a person's Social Security Number.

From then on, the score reflects one's personal financial history. If a person always pays bills on time, does not use too much of the available credit at once, and avoids negative information like foreclosures and charge-offs, the person will develop a good personal credit score, also known as a FICO score. If, instead, one carries a balance on lines of credit, fails to develop a diverse mix of credit sources—different credit cards, an automobile loan, and a mortgage, for example—and accrues many "hard inquiries" on your credit score (which occurs when upon application for a new source of credit),

[508] *Id.*
[509] *Id.* at 23.
[510] Consumer Financial and Protection Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports,* July 27, 2022, available at https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/ (last viewed on January 5, 2024).
[511] *Id.*

the FICO score will be low. Personal credit scores generally range 350-800 with 800 being a "perfect" score.

In 2018-2020, more than a quarter of the nation's largest hospitals and health systems pursued nearly 39,000 legal actions regarding consumer medical debt.[512]

Medical Debt Collection Process

Current law provides a court process for the collection of lawful debts, including medical debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding monetary damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means to collect on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current law provides that certain property is exempt from being taken by a creditor. The Florida Constitution provides that the debtor's homestead and $1,000 of personal property is exempt.[513] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[514]

In addition to the protection from creditors contained in the Florida Constitution, chapter 222, F.S., protects other personal property from certain claims of creditors and legal process: garnishment of wages for a head of family;[515] proceeds from life insurance policies;[516] wages or unemployment compensation payments due certain deceased employees;[517] disability income benefits;[518] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[519] $1,000 interest in a motor vehicle; professionally prescribed health aids; certain refunds or credits from financial institutions; and $4,000 interest in personal property, if the debtor does not claim or receive the benefits of a homestead exemption under the State Constitution.[520]

Bankruptcy is a means by which a person's assets are liquidated in order to pay the person's debts under court supervision. The United States Constitution gives Congress the right to uniformly govern bankruptcy law.[521] Bankruptcy courts are operated by the federal government. A debtor (the bankrupt person) is not required to give up all of his or her assets in bankruptcy. Certain property is deemed "exempt" from the bankruptcy case, and may be kept by the debtor without being subject to creditor claims. The Bankruptcy Code provides for exempt property in a bankruptcy case.[522] In general, a debtor may choose to utilize the exempt property listing in state law or the exempt property of the Bankruptcy Code. However, federal law allows a state to opt-out of the federal law and thereby insist that debtors only utilize state law exemptions.[523] Florida, like most states, has made the opt-out

[512] Using data from Johns Hopkins University, study authors analyzed the top 100 hospitals in the U.S. (by revenue) to measure debt collection methods and frequency, average charges markups and billing scores, and compare that data to safety grades and charity care ratings, by hospital type (government, nonprofit and for-profit). See, "How America's top hospitals hound patients with predatory billing", July 2021, available at https://www.axios.com/hospital-billing (last viewed March 26, 2023). Twelve Florida hospitals were included in the analysis, with a wide range of scores in each category.
[513] Art. X, s. 4(a), Fla. Const.
[514] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[515] S. 222.11, F.S.
[516] S. 222.13, F.S.
[517] S. 222.15, F.S.
[518] S. 222.18, F.S.
[519] S. 222.22, F.S.
[520] S. 222.25, F.S.
[521] Art. 1, s. 8, cl. 4, U.S. Const.
[522] 11 U.S.C. s. 522.
[523] 11 U.S.C. s. 522(b).

election to prohibit the use of the federal exemptions and require that debtors may only use state law exemptions.[524]

Statutes of Limitations

A statute of limitations bars a lawsuit's filing after a certain amount of time elapses following an injury.[525] This time period typically begins to run when a cause of action accrues (that is, on the date of the injury), but may also begin to run on the date the injury is discovered or on which it would have been discovered with reasonable efforts.[526] In other words, a statute of limitations bars the available civil remedy if a lawsuit is not timely filed after an injury.

Chapter 95, F.S., contains the bulk of Florida's statutes of limitations. Specifically, s. 95.11, F.S., details a variety of statutes of limitation for legal actions other than for recovery of real property. Some of the limitations require legal actions to be commenced as follows:

- WITHIN TWENTY YEARS.—An action on a judgment or decree of a court of record in this state.[527]
- WITHIN FIVE YEARS.—
    - An action on a judgment or decree of any court, not of record, of this state or any court of the United States, any other state or territory in the United States, or a foreign country.
    - A legal or equitable action on a contract, obligation, or liability founded on a written instrument, except for an action to enforce a claim against a payment bond, which shall be governed by the applicable provisions of paragraph (5)(e), s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by paragraph (5)(h).
    - An action to foreclose a mortgage.
    - An action alleging a willful violation of s 448.110.
    - Notwithstanding paragraph (b), an action for breach of a property insurance contract, with the period running from the date of loss.[528]
- WITHIN FOUR YEARS.—
    - An action founded on negligence.
    - An action relating to the determination of paternity, with the time running from the date the child reaches the age of majority.
    - ~~c~~ An action founded on the design, planning, or construction of an improvement to real property, with the time running from the date of actual possession by the owner, the date of the issuance of a certificate of occupancy, the date of abandonment of construction if not completed, or the date of completion of the contract or termination of the contract between the professional engineer, registered architect, or licensed contractor and his or her employer, ~~whichever date is latest, with some exceptions.~~
    - An action to recover public money or property held by a public officer or employee, or former public officer or employee, and obtained during, or as a result of, his or her public office or employment.
    - An action for injury to a person founded on the design, manufacture, distribution, or sale of personal property that is not permanently incorporated in an improvement to real property, including fixtures.
    - An action founded on a statutory liability.
    - An action for trespass on real property.
    - An action for taking, detaining, or injuring personal property.
    - An action to recover specific personal property.

[524] S. 222.20, F.S.
[525] Legal Information Institute, Statute of Limitations, https://www.law.cornell.edu/wex/statute_of_limitations (last visited January 3, 2024).
[526] *Id.*
[527] S. 95.11(1), F.S.
[528] S. 95.11(2), F.S.

- A legal or equitable action founded on fraud.
- A legal or equitable action on a contract, obligation, or liability not founded on a written instrument, including an action for the sale and delivery of goods, wares, and merchandise, and on store accounts.
- An action to rescind a contract.
- An action for money paid to any governmental authority by mistake or inadvertence.
- An action for a statutory penalty or forfeiture.
- An action for assault, battery, false arrest, malicious prosecution, malicious interference, false imprisonment, or any other intentional tort, except as provided in subsections (4), (5), and (7).
- Any action not specifically provided for in these statutes.
- An action alleging a violation, other than a willful violation, of s. 448.110.[529]

- WITHIN TWO YEARS.—
  - An action founded on negligence.
  - An action for professional malpractice, other than medical malpractice, whether founded on contract or tort; provided that the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
  - ~~e~~ An action for medical malpractice shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence. However, the limitation of actions herein for professional malpractice shall be limited to persons in privity with the professional**.**
  - An action to recover wages or overtime or damages or penalties concerning payment of wages and overtime.
  - An action for wrongful death.
  - An action founded upon a violation of any provision of chapter 517, with the period running from the time the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence, but not more than 5 years from the date such violation occurred.
  - An action for personal injury caused by contact with or exposure to phenoxy herbicides while serving either as a civilian or as a member of the Armed Forces of the United States during the period January 1, 1962, through May 7, 1975; the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
  - An action for libel or slander.[530]
- WITHIN ONE YEAR.—
  - An action for specific performance of a contract.
  - An action to enforce an equitable lien arising from the furnishing of labor, services, or material for the improvement of real property.
  - An action to enforce rights under the Uniform Commercial Code—Letters of Credit, chapter 675.
  - An action against any guaranty association and its insured, with the period running from the date of the deadline for filing claims in the order of liquidation.
  - Except for actions governed by s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), an action to enforce any claim against a payment bond on which the principal is a contractor, subcontractor, or sub-subcontractor as defined in s. 713.01, for private work as well as public work, from the last furnishing of labor, services, or materials or from the last furnishing of labor, services, or materials by the contractor if the contractor is the principal on a bond on the same construction project, whichever is later.

[529] S. 95.11(3), F.S.
[530] S. 95.11(4), F.S.

- Except for actions described in subsection (8), a petition for extraordinary writ, other than a petition challenging a criminal conviction, filed by or on behalf of a prisoner as defined in s. 57.085.
- Except for actions described in subsection (8), an action brought by or on behalf of a prisoner, as defined in s. 57.085, relating to the conditions of the prisoner's confinement.
- An action to enforce a claim of a deficiency related to a note secured by a mortgage against a residential property that is a one-family to four-family dwelling unit. The limitations period shall commence on the day after the certificate is issued by the clerk of court or the day after the mortgagee accepts a deed in lieu of foreclosure.[531]

Direct Health Care Agreements

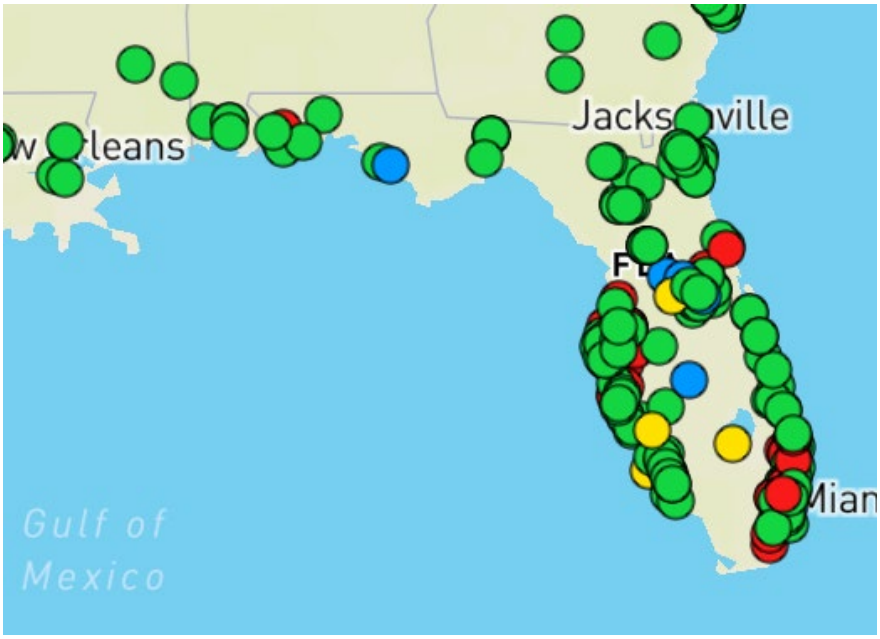
Created in Florida law by the 2008 Legislature,[532] *direct health care agreements*, are non-insurance contracts between certain, statutorily designated health care providers or groups of providers and patients. Such agreements are not subject to the Florida Insurance Code and are not regulated by the Department of Financial Services or the Office of Insurance Regulation. The direct provider arrangement eliminates third party payors and instead creates a contractual relationship between the health care provider and the patient usually with a small monthly fee (usually around $70 per individual) for access to the designated scope of benefits.

These agreements must adhere to specific statutory requirements to be a valid agreement. The requirements for a valid agreement are for the agreement to:

- Be in writing.
- Be signed by the health care provider or an agent of the health care provider and the patient, the patient's legal representative, or the patient's employer.
- Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.
- Describe the scope of health care services that are covered by the monthly fee.
- Specify the monthly fee and any fees for health care services not covered by the monthly fee.
- Specify the duration of the agreement and any automatic renewal provisions.
- Offer a refund to the patient, the patient's legal representative, or the patient's employer of monthly fees paid in advance if the health care provider ceases to offer health care services for any reason.
- Contain, in contrasting color and in at least 12-point type, the following statement on the signature page: "This agreement is not health insurance and the health care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any health care services covered by the agreement. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act, 26 U.S.C. s. 5000A. This agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440.[533]

[531] S. 95.11(5), F.S.
[532] Ch. Law 2018-89, L.O.F.
[533] S. 624.67(4)(a)-(h), F.S.

The Direct Primary Care Coalition reports over 1,000 associated practices.[534] On the map below, each green dot equals a pure direct primary care model, a red dot is a hybrid model, and a blue dot equals an onsite model. A provider with a hybrid model may have a mix of both direct primary care patients as well as other patients.



Patients who seek services under these agreements may see health care providers for any services for which the provider is licensed and has the competency and training to provide.[535] In Florida, state law allows direct health care arrangements to include: Currently, direct health care arrangements are limited to those defined as a "health care provider", and as designated by a specific licensure type. Those provider types are:

- Chapter 458 (medical doctors);
- Chapter 459 (osteopathic doctors);
- Chapter 460 (chiropractic physicians);
- Chapter 461 (podiatrists);
- Chapter 464 (nursing, including advanced or specialized nursing practice, advanced practice registered nurse, licensed practice nurse, or registered nurse);
- Chapter 466 (dental or dental hygienist), or
- A health care group practice, who provides health care services to patients.[536]

Effect of the bill - Health Care Price Transparency and Medical Debt

The bill increases patient access to health care cost information, and offers a measure of protection from unreasonable and burdensome medical debt. The various provisions apply to hospitals, ambulatory surgical centers, health insurers, and HMOs. The bill brings provisions from recent federal law and regulation into the Florida Statutes; in doing so, the bill requires compliance by facilities and

[534] Direct Primary Care Coalition, *Direct Primary Care Mapper,* available at https://mapper.dpcfrontier.com/ (last viewed January 5, 2024).
[535] S. 624.67(1)(c), F.S.
[536] S. 624.27(1)(b), F.S.

insurers as a condition of state licensure, thus ensuring that these provisions will be fully adopted and adequately enforced in Florida.[537]

Facility Price Transparency

Facility Billing Estimates

The bill requires that all patients receive cost-of-care information prior to receiving scheduled, nonemergency treatment in hospitals and ambulatory surgical centers, and from physicians providing services in those facilities.

At present, licensed facilities are required to provide a customized estimate of "reasonably anticipated charges" to a patient for treatment of the patient's specific condition, *upon request of the patient*. The bill makes these personalized estimates mandatory, rather than dependent on patient requests. A facility must submit the estimate of charges to a patient's health plan at least 3 business days before a service is to be furnished, according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after the service is scheduled;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after a service is scheduled.

By requiring facilities to provide a good-faith estimate of charges to each patient in advance of treatment, the bill mirrors the requirements of the federal No Surprises Act. Compliance with the Act was required by January 1, 2022.

Shoppable Services

The bill requires each licensed hospital and ambulatory surgical center to post a consumer-friendly list of standard charges for at least 300 shoppable health care services on a facility website. A facility that provides less than 300 distinct services will be required to post standard charges for each service it does provide.

The bill requires facilities to post pricing information for shoppable services in accordance with the definition of "standard charges" established in federal rule.[538] This information extends beyond the traditional concept of charges to include negotiated and actual prices paid for selected services. For each shoppable service, a hospital must disclose the following pricing benchmarks:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This bill is intended to mirror the shoppable services requirement included in the hospital facility transparency regulations finalized by the CMS in 2019. The bill requires facilities to disclose the relevant cost information as a condition of state licensure, which should result in uniform compliance among facilities.

Facility Medical Debt Collection

[537] SS. 395.003, 395.301, 408.802, 624.401, and 641.22, F.S.
[538] *Supra*, note 450.

The bill prohibits hospitals and ASCs from engaging in any "extraordinary collection actions" against a patient prior to determining whether that patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, for 30 days after notifying a patient in writing that a collections action will commence, and while the patient is negotiating in good faith the final amount of the bill or is complying with the terms of a payment plan with the facility. For purposes of the provision, "extraordinary collection action" means any action that requires a legal or judicial process, including:

- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest; or,
- Garnishing an individual's wages.

The bill also establishes a new set of debt collection exemptions in chapter 222, F.S. that apply explicitly to debt incurred as a result of medical services provided in hospitals, ambulatory surgical centers, or urgent care centers. Under current law, this type of medical debt is subject to the uniform exemptions that apply to all types of debt and are described above. The bill increases the ceiling on the debt collection exemptions, when the debt results from services provided in a hospital facility or ambulatory surgical center, as follows:

- To $10,000 interest in a single motor vehicle (versus the current law exemption of $1,000);
- To $10,000 interest in personal property, provided that a debtor does not claim the homestead exemption under s. 4, Art. X of the state constitution (versus the current law exemption of $4,000).

The bill also requires each hospital and ASC to establish an internal grievance process allowing a patient to dispute any charges that appear on an itemized statement or bill. When a patient initiates a grievance, the facility must then provide an initial response to that patient within 7 business days.

Lastly, the bill creates a three-year statute of limitations for any legal action related to medical debt for services rendered by a facility licensed under chapter 395, F.S., such as hospitals, ambulatory surgical centers, and urgent care centers. The statute of limitations begins running on the date that the facility refers the debt to a third-party collection entity.

Insurer Price Transparency

Shared Savings Programs

The bill establishes an accounting standard to remove a barrier to shared savings incentive programs. It specifies that insurer shared savings payments to patients shall be counted as medical expenses for rate development and rate filing purposes.[539] This change aligns Florida law with the federal regulations that became final in 2020.[540]

Advanced Explanation of Benefits

Effective July 1, 2022, the bill requires health plans to issue an advance explanation of benefits statement when a covered patient schedules a service in a hospital or ambulatory surgical center. This requirement builds on the facility charges estimate provision in the bill. Once a facility notifies a health

[539] Current law indicates that a shared savings incentive offered by a health plan is "not an administrative expense for rate development or rate filing purposes," but does not affirmatively categorize the expense. SS. 627.6387, 627.6648, and 641.31076, F.S.
[540] *Supra*, note 454.

plan that a patient has scheduled a medical service, the health plan must prepare a personalized estimate of costs for the patient in accordance with the federal No Surprises Act. A health plan must provide an advanced explanation of benefits to the patient according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after receiving the estimate of charges from the facility;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after receiving the estimate of charges from the facility.

Health insurers and HMOs were required comply with the federal Act by January 1, 2022.

Cash Price Communication

Under the Public Health Services Act, section 2799A-9(a)(2), health insurance issuers that offer individual health insurance coverage are prohibited from entering into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the issuer from—

(1) Providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or
(2) Sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in (1) with a business associate, consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, GINA, and the ADA.[541]

These regulations further restrict group health plans and health plan issuers from restricting the release of provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage.[542]

The first attestation of compliance from health plans and issuers was due on December 31, 2023 and will be due annually thereafter.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.4018, F.S., relating to physician workforce assessment and development.
Section 2: Amends s. 381.4019, F.S., relating to dental student loan repayment program.
Section 3: Amends s. 1009.65, F.S., relating to medical education reimbursement and loan repayment program.
Section 4: Creates s. 381.4021, F.S., relating to student loan repayment programs reporting.
Section 5: Creates s. 381.9855, F.S., relating to health care screening and services grant program.
Section 6: Amends s. 383.2163, F.S., relating to telehealth minority maternity care pilot programs.
Section 7: Amends s. 383.302, F.S., relating to definitions.
Section 8: Creates s. 383.3081, F.S., relating to advanced birth center designation.
Section 9: Amends s. 383.309, F.S., relating to minimum standards for birth centers; rules and enforcement.
Section 10: Amends s. 383.313, F.S., relating to performance of laboratory and surgical services; use of anesthetic and chemical agents.

[541] Centers for Medicare and Medicaid Services, *Gag Clause Prohibition Attestation Compliance,* https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/gag-clause-prohibition-compliance-attestation (last viewed January 6, 2024).
[542] *Id.*

Section 11: Creates s. 383.3131, F.S., relating to advanced birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.
Section 12: Amends s. 383.315, F.S., relating to agreements with consultants for advice or services; maintenance.
Section 13: Amends s. 383.316, F.S., relating to transfer and transport of clients to hospitals.
Section 14: Amends s. 383.318, F.S., relating to postpartum care for birth center clients and infants.
Section 15: Amends s. 394.455, F.S., relating to definitions.
Section 16: Amends s. 394.457, F.S., relating to operations and administration.
Section 17: Amends s. 394.4598, F.S., relating to guardian advocate.
Section 18: Amends s. 394.4615, F.S., relating to clinical records; confidentiality.
Section 19: Amends s. 394.4625, F.S., relating to voluntary admissions.
Section 20: Amends s. 394.463, F.S., relating to involuntary examination.
Section 21: s. 394.4655, F.S., relating to involuntary outpatient services.
Section 22: Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 23: Amends s. 394.4781, F.S., relating to residential care for psychotic and emotionally disturbed children.
Section 24: Amends s. 394.4785, F.S., relating to children and adolescents; admission and placement in mental facilities.
Section 25: Creates an unnumbered section of law, relating to Medicaid coverage of mobile crisis response services.
Section 26: Amends s. 394.875, F.S., relating to crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.
Section 27: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 28: Amends s. 395.301, F.S., relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 29: Creates s. 395.3011, F.S., relating to billing and collection activities.
Section 30: Amends s. 408.051, F.S., relating to Florida Electronic Health Records Exchange Act.
Section 31: Amends s. 409.909, F.S., relating to Statewide Medicaid Residency Program.
Section 32: Creates s. 409.91256, F.S., relating to Training, Education, and Clinicals in Health Funding Program.
Section 33: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 34: Amends s. 409.973, F.S., relating to benefits.
Section 35: Creates an unnumbered section of law, relating to Medicaid hospital care at home.
Section 36: Creates s. 456.0145, F.S., relating to Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.
Section 37: Amends s. 456.073, F.S., relating to disciplinary proceedings.
Section 38: Amends s. 456.076, F.S., relating to impaired practitioner programs.
Section 39: Creates s. 456.4501, F.S., relating to Interstate Medical Licensure Compact.
Section 40: Creates s. 456.4502, F.S., relating to Interstate Medical Licensure Compact; disciplinary proceedings.
Section 41: Creates s. 456.4504, F.S., relating to Interstate Medical Licensure Compact rules.
Section 42: Creates an unnumbered section of law, relating to Interstate Medical Licensure Compact fees.
Section 43: Amends s. 457.105, F.S., relating to licensure qualifications and fees.
Section 44: Amends s. 458.311, F.S., relating to licensure by examination; requirements; fees.
Section 45: Repeals s. 458.3124, F.S., relating to restricted license; certain experienced foreign-trained physicians.
Section 46: Amends s. 458.313, F.S., relating to licensure by endorsement; requirements; fees.
Section 47: Amends s. 458.314, F.S., relating to certification of foreign educational institutions.
Section 48: Amends s. 458.3145, F.S., relating to medical faculty certificate.
Section 49: Amends s. 458.315, F.S., relating to temporary certificate for practice in areas of critical need.
Section 50: Amends s. 458.317, F.S., relating to limited licenses.
Section 51: Amends s. 459.0075, F.S., relating to limited licenses.

Section 52: Amends s. 459.0076, F.S., relating to temporary certificate for practice in areas of critical need.
Section 53: Amends s. 464.009, F.S., relating to licensure by endorsement.
Section 54: Creates s. 464.0121, F.S., relating to temporary certificate for practice in areas of critical need.
Section 55: Amends s. 464.0123, F.S., relating to autonomous practice by an advanced practice registered nurse.
Section 56: Amends s. 464.019, F.S., relating to approval of nursing education programs.
Section 57: Amends s. 465.0075, F.S., relating to licensure by endorsement; requirements; fee.
Section 58: Amends s. 467.0125, F.S., relating to licensed midwives; qualifications; endorsement; temporary certificates.
Section 59: Amends s. 468.1705, F.S., relating to licensure by endorsement; temporary license.
Section 60: Repeals s. 468.213, F.S., relating to licensure by endorsement.
Section 61: Amends s. 468.3065, F.S., relating to certification by endorsement.
Section 62: Repeals s. 468.358, F.S., relating to licensure by endorsement.
Section 63: Amends s. 478.47, F.S., relating to licensure by endorsement.
Section 64: Amends s. 480.041, F.S., relating to massage therapists; qualifications; licensure endorsement.
Section 65: Amends s. 486.081, F.S., relating to physical therapist.
Section 66: Amends s. 491.006, F.S., relating to licensure or certifications by endorsement.
Section 67: Creates s. 458.3129, F.S., relating to Interstate Medical Licensure Compact.
Section 68: Creates s. 459.074, F.S., relating to Interstate Medical Licensure Compact.
Section 69: Amends s. 468.1135, F.S., relating to board of speech-language pathology and audiology.
Section 70: Amends s. 468.1185, F.S., relating to licensure.
Section 71: Amends s. 468.1295, F.S., relating to disciplinary proceedings.
Section 72: Creates s. 468.1335, F.S., relating to Practice of Audiology and Speech-Language Pathology Interstate Compact.
Section 73: Creates an unnumbered section of law, relating to Audiology and Speech-Language Pathology Interstate Compact fees.
Section 74: Amends s. 486.028, F.S., relating to license to practice physical therapy required.
Section 75: Amends s. 486.031, F.S., relating to physical therapist; licensing requirements.
Section 76: Amends s. 486.102, F.S., relating to physical therapist assistant; licensing requirements.
Section 77: Amends s. 486.107, F.S., relating to physical therapist assistant.
Section 78: Amends s. 490.006, F.S., relating to licensure by endorsement.
Section 79: Creates s. 486.112, F.S., relating to Physical Therapy Licensure Compact.
Section 80: Creates an unnumbered section of law, relating to Physical Therapy Licensure Compact fees.
Section 81: Amends s. 486.023, F.S., relating to board of physical therapy practice.
Section 82: Amends s. 486.125, F.S., relating to refusal, revocation, or suspension of license; administrative fines and other disciplinary measures.
Section 83: Amends s.624.27, F.S., relating to direct health care agreements; exemption from code.
Section 84: Amends s. 95.11, F.S., relating to limitations other than for the recovery of real property.
Section 85: Creates s. 222.26, F.S., relating to additional exemptions from legal process concerning medical debt.
Section 86: Creates s. 627.446, F.S., relating to advanced explanation of benefits.
Section 87: Creates s. 627.447, F.S., relating to disclosure of discounted cash prices.
Section 88: Amends s. 627.6387, F.S., relating to shared savings incentive program.
Section 89: Amends s. 627.6648, F.S., relating to shared savings incentive program.
Section 90: Amends s. 641.31076, F.S., relating to shared savings incentive program.
Section 91: Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
Section 92: Amends s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.

Section 93: Amends s. 1002.32, F.S., relating to developmental research (laboratory) schools.
Section 94: Amends s. 1004.015, F.S., relating to Florida Development Council.
Section 95: Amends s. 1009.8962, F.S., relating to the Linking Industry to Nursing Education (LINE) fund.
Section 96: Amends s. 486.025, F.S., relating to powers and duties of the Board of Physical Therapy Practice.
Section 97: Amends s. 486.0715, F.S., relating to physical therapist; insurance of temporary permit.
Section 98: Amends s. 486.1065, F.S., relating to physical therapist assistant; issuance of temporary permit.
Section 99: Amends s. 395.602, F.S., relating to rural hospitals.
Section 100: Amends s. 458.316, F.S., relating to public health certificate.
Section 101: Amends s. 458.3165, F.S., relating to public psychiatry certificate.
Section 102: Amends s. 468.209, F.S., relating to requirements for licensure.
Section 103: Amends s. 468.511, F.S., relating to dietitian/nutritionist; temporary permit.
Section 104: Amends s. 475.01, F.S., relating to definitions.
Section 105: Amends s. 475.611, F.S., relating to definitions.
Section 106: Amends s. 517.191, F.S., relating to injunction to restrain violations; civil penalties; enforcement by Attorney General.
Section 107: Amends s. 787.061, F.S., relating to civil actions by victims of human trafficking.
Section 108: Appropriates funds to DOH for the Florida Reimbursement Assistance for Medical Education Program.
Section 109: Appropriates funds to DOH for the Dental Student Loan Repayment Program.
Section 110: Appropriates funds to DOH to expand statewide the telehealth minority maternity care program.
Section 111: Appropriates funds to AHCA to implement the TEACH Funding program.
Section 112: Appropriates funds to UF, FSU, FAU, and FAMU to implement lab school articulated health care programs.
Section 113: Appropriates funds to DOE to implement the LINE fund.
Section 114: Appropriates funds to AHCA for the Slots for Doctors Program.
Section 115: Appropriates funds to AHCA to provide to statutory teaching hospitals.
Section 116: Appropriates funds to AHCA to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping reimbursement methodology and increase the existing marginal cost percentages for transplant pediatrics, pediatrics, and neonates.
Section 117: Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for dental care services.
Section 118: Appropriates funds to APD to provide a uniform iBudget Waiver provider rate increase; appropriates funds to AHCA to establish budget authority for Medicaid services.
Section 119: Appropriates funds to DCF to enhance crisis diversion through mobile response teams.
Section 120: Appropriates funds to DOH to implement the Heath Care Screening and Services Grant Program.
Section 121: Appropriates funds to AHCA to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers.
Section 122: Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses.
Section 123: Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers.
Section 124: Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services.
Section 125: Provides the bill will take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill will have a significant, negative fiscal impact on DOH and AHCA related to the implementation of the bill's various provisions. The exact amount is currently unknown as the agencies have not yet provided a fiscal analysis but it is anticipated that these costs will be substantial.

   Additionally, the bill provides the following appropriations for the 2024-2025 state fiscal year:

   - The sum of $25 million in nonrecurring funds from the General Revenue Fund is appropriated to the DOH for FRAME.
   - The sum of $8 million in nonrecurring funds from the General Revenue Fund is appropriated to the DOH for the DSLR Program.
   - The sum of $23,357,876 in recurring funds from the General Revenue Fund is appropriated to the DOH to expand statewide the telehealth minority maternity care program. This appropriation directs the DOH to establish 15 regions in which to implement the program statewide based on the location of hospitals providing obstetrics and maternity care and pertinent data from nearby counties for severe maternal morbidity and maternal mortality. The DOH must identify the criteria for selecting providers for regional implementation and, at a minimum, consider the maternal level of care designations for hospitals within the regions, the neonatal intensive care unit levels of hospitals within the regions, and the experience of community-based organizations to screen for and treat common pregnancy-related complications.
   - The sum of $15 million in recurring funds from the General Revenue Fund is appropriated to the AHCA to implement the TEACH Funding Program.
   - The sum of $2 million in recurring funds from the General Revenue Fund is appropriated to the University of Florida, Florida State University, Florida Atlantic University, and Florida Agricultural and Mechanical University for the purpose of implementing lab school articulated health care programs. Each state university will receive $500,000 from this appropriation.
   - The sum of $5 million in recurring funds from the General Revenue Fund is appropriated to the Department of Education for the purpose of implementing the Linking Industry to Nursing Education (LINE) Fund.
   - The sums of $14,920,500 in recurring funds from the General Revenue Fund and $20,079,500 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA for the Slots for Doctors Program.
   - The sums of $42,630,000 in recurring funds from the Grants and Donations Trust Fund and $57,370,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide to statutory teaching hospitals as defined in s. 408.07(46), F.S., meeting certain criteria, distributed according to specified parameters.
   - The sums of $32,464,472 in recurring funds from the General Revenue Fund and $43,689,578 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping (DRG) reimbursement methodology and increase the existing marginal cost percentages for transplant pediatrics, pediatrics, and neonates.
   - The sums of $29,209,696 in recurring funds from the General Revenue Fund and $39,309,413 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community Based Services Waiver category to the Agency

for Persons with Disabilities to provide a uniform iBudget Waiver provider rate increase. The sum of $68,519,109 in recurring funds from the Medical Care Trust Fund is appropriated in the Home and Community Based Services Waiver category to the AHCA to establish budget authority for Medicaid services.

- The sum of $11,525,152 in recurring funds from the General Revenue Fund is appropriated to the Department of Children and Families to enhance crisis diversion through mobile response teams by adding an additional 16 mobile response teams to ensure coverage in every county.
- The sum of $1 million in recurring funds from the General Revenue Fund is appropriated to the DOH to implement the Health Care Screening and Services Grant Program.
- The sum of $150,000 in nonrecurring funds from the General Revenue Fund and $150,000 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the AHCA to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers.
- Effective October 1, 2024, the sums of $14,888,903 in recurring funds from the General Revenue Fund and $20,036,979 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for dental care services. The funds shall be held in reserve and released upon approval of a budget amendment pursuant to chapter 216, Florida Statutes. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $12,365,771 in recurring funds from the General Revenue Fund, $127,300 in recurring funds from the Refugee Assistance Trust Fund, and $16,514,132 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $14,580,660 in recurring funds from the General Revenue Fund and $19,622,154 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $9,666,352 in recurring funds from the General Revenue Fund and $13,008,646 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have an indeterminate positive fiscal impact on health care practitioners who are able to participate in FRAME or the DSLR Program.

The bill may have an indeterminate positive fiscal impact for nonprofit entities that take advantage of the Health Care Screening and Services Grant program or anyone who is able to find free or reduced cost services through the DOH's portal.

The bill may have an indeterminate positive fiscal impact on facilities that participate in the TEACH program.

The bill may have an indeterminate positive fiscal impact on nursing schools that are able to participate in the LINE program due to changes made in the bill.

The bill could allow physicians who do not match for a residency following graduation from medical school to enter the Florida physician workforce faster and help reduce the health care provider shortage.

The bill may increase costs for facilities licensed under ch. 395, F.S., by requiring them to issue cost estimates for all non-emergency patients, but only if the facilities are out of compliance with the current federal requirement to provide these estimates.

Facilities may forego revenues due to the bill's limits on the use of extraordinary collection activities; however, some facilities may already be providing similar due process for patients, such that the bill will have little impact on them.

The bill may have a negative, but indeterminate, fiscal impact on health insurers and HMOs, due to the costs of producing advanced explanations of benefits for insureds and subscribers, triggered by the estimates provided by facilities, but only if these health plans are out of compliance with the current federal requirement to provide these to subscribers.

Additionally, the bill's increased dollar limit on personal property exemptions under ch. 222, F.S., may reduce revenues for medical service providers or their collection agents.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments

2. Other:

Fees

Pursuant to Article 7 Section 19 of the Florida Constitution, new taxes or fees imposed by the Legislature must be approved by a two-thirds vote of both Legislative chambers in a bill containing no other subject. This requirement does not apply to fees authorized under current law.

There are no new fee provisions in the bill. The fee provisions contained within the bill move or reiterate existing fee requirements in current law. As such, the bill's provisions do not implicate Article 7 Section 19 of the Florida Constitution.

Compacts

The multistate compacts enacted in the bill authorize their commissions to adopt reasonable rules to effectively and efficiently achieve the purposes of the compacts, and these rules carry the force of law in member states, which is potentially an unlawful delegation of legislative authority. If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the commissions.

The Legislature delegated similar rulemaking powers to compact commissions when it adopted the compact language for the Nurse Licensure Compact, Professional Counselors Licensure Compact, and the Psychology Interjurisdictional Compact into statute. The rules adopted by these compacts are now applicable to Florida without the Legislature's subsequent approval, similar to what the state would encounter with the enactment of multistate compacts under the bill and the included rulemaking provisions. In the case of these compacts, should Florida find that rules adopted by any of the three commissions are not acceptable, the compacts provide a mechanism for a majority of state legislatures to override commission rules. Furthermore, the state maintains the ability to withdraw from any of the compacts.

B. RULE-MAKING AUTHORITY:

The bill provides requisite authority to all impacted state agencies and boards necessary to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care; amending s. 381.4018, F.S.; requiring physician licensees to provide to the Department of Health specified information; requiring the department to collect and compile such information in consultation with the Office of Program Policy Analysis and Government Accountability; amending s. 381.4019, F.S.; revising the purpose of the Dental Student Loan Repayment Program; defining the term "free clinic"; including dental hygienists in the program; revising eligibility requirements for the program; specifying limits on award amounts for and participation of dental hygienists under the program; deleting the maximum number of new practitioners who may participate in the program each fiscal year; specifying that dentists and dental hygienists must provide specified documentation; requiring practitioners who receive payments under the program to furnish certain information requested by the Department of Health; requiring the Agency for Health Care Administration to seek federal authority to use specified matching funds for the program; providing for future repeal of the program; transferring, renumbering, and amending s. 1009.65, F.S.; renaming the Medical Education Reimbursement and Loan Repayment

Program as the "Florida Reimbursement Assistance for Medical Education Program"; revising the types of providers who are eligible to participate in the program; revising requirements for the distribution of funds under the program; requiring the Agency for Health Care Administration to seek federal authority to use specified matching funds for the program; creating s. 381.4021, F.S.; requiring the Department of Health to provide to the Governor and the Legislature an annual report on specified student loan repayment programs; providing requirements for the report; requiring the department to contract with an independent third party to develop and conduct a design study for evaluating the effectiveness of specified student loan repayment programs; specifying requirements for the design study; requiring the department to submit the study results to the Governor and the Legislature by dates certain; requiring the department to participate in a certain multistate collaborative for a specified purpose; providing for future repeal of the requirement; creating s. 381.9855, F.S.; requiring the department to implement a health care screening and services grant program for a specified purpose; specifying duties of the department; authorizing nonprofit entities to apply

for grant funds to implement new health care screening, service programs, or mobile clinics or units to expand the program's delivery capabilities; specifying requirements for grant recipients; authorizing the department to adopt rules; requiring the department to create and maintain an Internet-based portal to provide specified information relating to available health care screenings and services and volunteer opportunities; authorizing the department to contract with a third-party vendor to create and maintain the portal; specifying requirements for the portal; requiring the department to coordinate with county health departments for a specified purpose; requiring the department to include a clear and conspicuous link to the portal on the homepage of its website; requiring the department to publicize and encourage the use of the portal and enlist the aid of county health departments for such outreach; amending s. 383.2163, F.S.; expanding the telehealth minority maternity care program from a pilot program to a statewide program; requiring the department to submit to the Governor and the Legislature an annual report; providing requirements for the report; amending s. 383.302, F.S.; providing and revising definitions; creating s. 383.3081, F.S.; providing requirements for

birth centers to be designated as advanced birth centers with respect to operating procedures, staffing, and equipment; requiring an advanced birth center to enter into a written agreement with a blood bank for emergency blood bank services; requiring that a patient who receives an emergency blood transfusion at an advanced birth center be immediately transferred to a hospital for further care; requiring the agency to establish by rule a process for birth centers to be designated as advanced birth centers; amending s. 383.309, F.S.; providing minimum standards for advanced birth centers; authorizing the Agency for Health Care Administration to enforce specified provisions of the Florida Building Code and the Florida Fire Prevention Code for advanced birth centers; amending s. 383.313, F.S.; conforming provisions to changes made by the act; creating s. 383.3131, F.S.; providing requirements for laboratory and surgical services at advanced birth centers; providing conditions for administration of anesthesia; authorizing the intrapartal use of chemical agents; amending s. 383.315, F.S.; requiring advanced birth centers to employ or maintain an agreement with an obstetrician for specified purposes; amending s. 383.316, F.S.; requiring advanced birth centers to

provide for the transport of emergency patients to a hospital; requiring each advanced birth center to enter into a written transfer agreement with a local hospital or an obstetrician for such transfers; requiring birth centers and advanced birth centers to assess and document transportation services and transfer protocols annually; amending s. 383.318, F.S.; providing protocols for postpartum care of clients and infants at advanced birth centers; providing requirements for followup care; amending s. 394.455, F.S.; revising definitions; amending s. 394.457, F.S.; requiring the Department of Children and Families to adopt certain minimum standards for mobile crisis response services; amending s. 394.4598, F.S.; authorizing certain psychiatric nurses to provide opinions to the court for the appointment of guardian advocates; authorizing certain psychiatric nurses to consult with guardian advocates for purposes of obtaining consent for treatment; amending s. 394.4615, F.S.; authorizing psychiatric nurses to make certain determinations related to the release of clinical records; amending s. 394.4625, F.S.; requiring certain treating psychiatric nurses to document specified information in a patient's clinical record within a specified timeframe of his or her

voluntary admission for mental health treatment; requiring clinical psychologists who make determinations of involuntary placement at certain mental health facilities to have specified clinical experience; authorizing certain psychiatric nurses to order emergency treatment for certain patients; amending s. 394.463, F.S.; authorizing certain psychiatric nurses to order emergency treatment of certain patients; requiring a clinical psychologist to have specified clinical experience to approve the release of an involuntary patient at certain mental health facilities; amending s. 394.4655, F.S.; requiring clinical psychologists to have specified clinical experience in order to recommend involuntary outpatient services for mental health treatment; authorizing certain psychiatric nurses to recommend involuntary outpatient services for mental health treatment; providing an exception; authorizing psychiatric nurses to make certain clinical determinations that warrant bringing a patient to a receiving facility for an involuntary examination; amending s. 394.467, F.S.; requiring clinical psychologists to have specified clinical experience in order to recommend involuntary inpatient services for mental health treatment; authorizing certain

psychiatric nurses to recommend involuntary inpatient services for mental health treatment; amending s. 394.4781, F.S.; revising the definition of the term "psychotic or severely emotionally disturbed child"; amending s. 394.4785, F.S.; authorizing psychiatric nurses to admit individuals over a certain age into certain mental health units of a hospital under certain conditions; requiring the agency to seek federal approval for Medicaid coverage and reimbursement authority for mobile crisis response services; requiring the Department of Children and Families to coordinate with the agency to provide specified education to contracted mobile response team services providers; amending s. 394.875, F.S.; authorizing certain psychiatric nurses to prescribe medication to clients of crisis stabilization units; amending s. 395.1055, F.S.; requiring the agency to adopt rules ensuring that hospitals do not accept certain payments and requiring certain hospitals to submit an emergency department diversion plan to the agency for approval before initial licensure or licensure renewal; providing that, beginning on a date certain, such plan must be approved before a license may be issued or renewed; requiring such hospitals to submit specified data to the agency on an annual basis

and update their plans as needed, or as directed by the agency, before each licensure renewal; specifying requirements for the diversion plans; requiring the agency to establish a process for hospitals to share certain information with certain patients' managed care plans; amending s. 395.301, F.S.; requiring a licensed facility to post on its website a consumer-friendly list of standard charges for a minimum number of shoppable health care services; providing definitions; requiring a licensed facility to provide an estimate to a patient or prospective patient and the patient's health insurer within specified timeframes; requiring a licensed facility to establish an internal grievance process for patients to dispute charges; requiring a facility to make available information necessary for initiating a grievance; requiring a facility to respond to a patient grievance within a specified timeframe; requiring licensed a facility to disclose specified information relating to cost sharing obligations to certain persons; providing a penalty; creating s. 395.3011, F.S.; defining the term "extraordinary collection action"; prohibiting certain collection activities by a licensed facility; amending s. 408.051, F.S.; requiring certain hospitals to make available certain data to the agency's Florida

Health Information Exchange program for a specified purpose; authorizing the agency to adopt rules; amending s. 409.909, F.S.; authorizing the agency to allocate specified funds under the Slots for Doctors Program for existing resident positions at hospitals and qualifying institutions if certain conditions are met; requiring hospitals and qualifying institutions that receive certain state funds to report specified data to the agency annually; requiring certain hospitals and qualifying institutions to annually report to the agency specified data; defining the term "sponsoring institution"; requiring such hospitals and qualifying institutions, beginning on a date certain, to produce certain financial records or submit to certain financial audits; providing applicability; providing that hospitals and qualifying institutions that fail to produce such financial records to the agency are no longer eligible to participate in the Statewide Medicaid Residency Program until a certain determination is made by the agency; requiring hospitals and qualifying institutions to request exit surveys of residents upon completion of residency; providing requirements for the exit surveys; creating the Graduate Medical Education Committee within the agency; providing for membership and meetings of the

committee; requiring the committee, beginning on a specified date, to submit to the Governor and the Legislature an annual report detailing specified information; requiring the agency to provide administrative support to assist the committee in the performance of its duties and to provide certain information to the committee; creating s. 409.91256, F.S.; creating the Training, Education, and Clinicals in Health (TEACH) Funding Program for a specified purpose; providing legislative intent; providing definitions; requiring the agency to develop an application process and enter into certain agreements to implement the program; specifying requirements to qualify to receive reimbursements under the program; requiring the agency, in consultation with the Department of Health, to develop, or contract for the development of, specified training for, and to provide assistance to, preceptors; providing for reimbursement under the program; requiring the agency to submit to the Governor and the Legislature an annual report; providing requirements for the report; requiring the agency to contract with an independent third party to develop and conduct a design study for evaluating the impact of the program; specifying requirements for the design study; requiring the agency to begin collecting

data for the study and submit the study results to the Governor and the Legislature by dates certain; authorizing the agency to adopt rules; requiring the agency to seek federal approval to use specified matching funds for the program; providing for future repeal of the program; amending s. 409.967, F.S.; requiring the agency to produce an annual report on patient encounter data under the statewide managed care program; providing requirements for the report; requiring the agency to submit to the Governor and the Legislature the report by a date certain; authorizing the agency to contract with a third-party vendor to produce the report; amending s. 409.973, F.S.; requiring Medicaid managed care plans to continue assisting certain enrollees in scheduling an initial appointment with a primary care provider; requiring such plans to coordinate with hospitals that contact them for a specified purpose; requiring the plans to coordinate with their members and members' primary care providers for such purpose; requiring the agency to seek federal approval necessary to implement an acute hospital care at home program meeting specified criteria; creating s. 456.0145, F.S.; providing a short title; providing definitions; requiring an applicable health care regulatory board, or the

department if there is no board, to issue a license or certification to applicants who meet specified conditions; requiring the department and the board to list on their respective websites jurisdictions that meet the minimum requirements for interstate licensure; authorizing the board or the department, as applicable, to require applicants to pass a specified examination under certain circumstances; creating a presumption that an applicant is qualified for interstate licensure, unless the board or department, as applicable, demonstrates otherwise; requiring the board or the department, as applicable, to provide applicants with a written decision within a specified timeframe; authorizing applicants to appeal certain decisions of a board or the department, as applicable; specifying that applicants granted an interstate license are still subject to the applicable laws and rules in this state and the jurisdiction of the applicable board, or the department if there is no board; providing applicability and construction; requiring the department to submit to the Governor and the Legislature an annual report by a date certain; providing requirements for the report; requiring the boards and the department to adopt rules, as applicable; amending s. 456.073, F.S.; requiring the

Department of Health to report certain investigative information to the data system; amending s. 456.076, F.S.; requiring that monitoring contracts for certain impaired practitioners participating in treatment programs contain specified terms; creating s. 456.4501, F.S.; enacting the Interstate Medical Licensure Compact in this state; providing purposes of the compact; providing that state medical boards of member states retain jurisdiction to impose adverse action against licenses issued under the compact; providing definitions; specifying eligibility requirements for physicians seeking an expedited license under the compact; providing requirements for designation of a state of principal license for purposes of the compact; authorizing the Interstate Medical Licensure Compact Commission to develop certain rules; providing an application and verification process for expedited licensure under the compact; providing for expiration and termination of expedited licenses; authorizing the Interstate Commission to develop certain rules; providing requirements for renewal of expedited licenses; authorizing the Interstate Commission to develop certain rules; providing for the establishment of a database for coordinating licensure data amongst

member states; requiring and authorizing member boards to report specified information to the database; providing for confidentiality of such information; providing construction; authorizing the Interstate Commission to develop certain rules; authorizing member states to conduct joint investigations and share certain materials; providing for disciplinary action of physicians licensed under the compact; creating the Interstate Medical Licensure Compact Commission; providing purpose and authority of the commission; providing for membership and meetings of the commission; providing public meeting and notice requirements; authorizing closed meetings under certain circumstances; providing public record requirements; requiring the commission to establish an executive committee; providing for membership, powers, and duties of the committee; authorizing the commission to establish other committees; specifying powers and duties of the commission; providing for financing of the commission; providing for organization and operation of the commission; providing limited immunity from liability for commissioners and other agents or employees of the commission; authorizing the commission to adopt rules; providing for rulemaking procedures, including public

notice and meeting requirements; providing for judicial review of adopted rules; providing for oversight and enforcement of the compact in member states; requiring courts in member states to take judicial notice of the compact and the commission rules for purposes of certain proceedings; providing that the commission is entitled to receive service of process and has standing in certain proceedings; rendering judgments or orders void as to the commission, the compact, or commission rules under certain circumstances; providing for enforcement of the compact; specifying venue and civil remedies in such proceedings; providing for attorney fees; providing construction; specifying default procedures for member states; providing for dispute resolution between member states; providing for eligibility and procedures for enactment of the compact; providing for amendment to the compact; specifying procedures for withdrawal from and subsequent reinstatement of the compact; authorizing the Interstate Commission to develop certain rules; providing for dissolution of the compact; providing severability and construction; creating s. 456.4502, F.S.; providing that a formal hearing before the Division of Administrative Hearings must be held if there are any disputed issues of

material fact when the licenses of certain physicians and osteopathic physicians are suspended or revoked by this state under the compact; requiring the Department of Health to notify the Division of Administrative Hearings of a petition for a formal hearing within a specified timeframe; requiring the administrative law judge to issue a recommended order; requiring the Board of Medicine or the Board of Osteopathic Medicine, as applicable, to determine and issue final orders in certain cases; providing the department with standing to seek judicial review of any final order of the boards; creating s. 456.4504, F.S.; authorizing the department to adopt rules; specifying that provisions of the Interstate Medical Licensure Compact do not authorize the Department of Health, the Board of Medicine, or the Board of Osteopathic Medicine to collect a fee for expedited licensure, but rather state that fees of that kind are allowable under the compact; amending s. 457.105, F.S.; revising requirements for a person to become licensed to practice acupuncture; amending s. 458.311, F.S.; revising an education and training requirement for physician licensure; exempting certain foreign-trained applicants for physician licensure from the residency requirement; providing certain employment requirements

for such applicants; requiring such applicants to notify the Board of Medicine of any changes in employment within a specified timeframe; repealing s. 458.3124, F.S., relating to restricted licenses of certain experienced foreign-trained physicians; amending s. 458.313; revising requirements for an applicant for licensure by endorsement to practice as a physician; amending s. 458.314, F.S.; authorizing the board to exclude certain foreign medical schools from consideration as an institution that provides medical education that is reasonably comparable to similar accredited institutions in the United States; providing construction; deleting obsolete language; amending s. 458.3145, F.S.; revising criteria for medical faculty certificates; deleting a cap on the maximum number of extended medical faculty certificates that may be issued at specified institutions; amending ss. 458.315 and 459.0076, F.S.; authorizing temporary certificates for practice in areas of critical need to be issued to physician assistants, rather than only to physicians, who meet specified criteria; amending ss. 458.317 and 459.0075, F.S.; specifying who may be considered a graduate assistant physician; creating limited licenses for graduate assistant physicians; specifying criteria a

person must meet to obtain such licensure; requiring the Board of Medicine and the Board of Osteopathic Medicine, respectively, to establish certain requirements by rule; providing for a one-time renewal of such licenses; authorizing limited licensed graduate assistant physicians to provide health care services only under the direct supervision of a physician and pursuant to a written protocol; providing requirements for, and limitations on, such supervision and practice; providing requirements for the supervisory protocols; providing that supervising physicians are liable for any acts or omissions of such graduate assistant physicians acting under their supervision and control; authorizing third-party payors to provide reimbursement for covered services rendered by graduate assistant physicians; authorizing the Board of Medicine and the Board of Osteopathic Medicine, respectively, to adopt rules; amending s. 464.009, F.S.; revising requirements for an applicant for licensure by endorsement to practice by endorsement to practice professional or practical nursing; creating s. 464.0121, F.S.; providing that temporary certificates for practice in areas of critical need may be issued to advanced practice registered nurses who meet specified criteria;

providing restrictions on the issuance of temporary certificates; waiving licensure fees for such applicants under certain circumstances; amending s. 464.0123, F.S.; requiring certain certified nurse midwives, as a condition precedent to providing out-of-hospital intrapartum care, to maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services; requiring that such policy prescribe and require the use of an emergency plan-of-care form; providing requirements for the form; requiring such certified nurse midwives to document specified information on the form if a transfer of care is determined to be necessary; requiring certified nurse midwives to verbally provide the receiving provider with specified information and make himself or herself immediately available for consultation; requiring certified nurse midwives to provide the patient's emergency plan-of-care form, as well as certain patient records, to the receiving provider upon the patient's transfer; requiring the Board of Nursing to adopt certain rules; amending s. 464.019, F.S.; deleting the sunset date of a certain annual report required of the Florida Center for Nursing; amending ss. 465.0075, 467.0125, 468.1705, 468.3065, 478.47, 480.041, and 491.006; revising

licensure requirements to include licensure by endorsement to practice as a pharmacist; midwife; nursing home administrator; radiologist, radiologic technologist, and specialty technologist; electrologist; or psychologist or school psychologist, respectively; repealing ss. 468.213 and 468.358, F.S., relating to licensure by endorsement for occupational therapists and respiratory therapists, respectively; creating s. 458.3129 and 459.074, F.S.; providing that an allopathic physician or an osteopathic physician, respectively, licensed under the compact is deemed to be licensed under ch. 458, F.S., or ch. 459, F.S., as applicable; amending s. 468.1135, F.S.; requiring the Board of Speech-Language Pathology and Audiology to appoint two of its board members to serve as the state's delegates on the compact commission; amending s. 468.1185, F.S.; removing provisions relating to licensure by endorsement and refusal of certification for speech-language pathologists and audiologists; exempting audiologists and speech-language pathologists from licensure requirements who are practicing in this state pursuant to a compact privilege under the compact; amending s. 468.1295, F.S.; authorizing the board to take adverse action against the compact privilege of audiologists and

speech-language pathologists for specified prohibited acts; creating s. 468.1335, F.S.; creating the Practice of Audiology and Speech-language Pathology Interstate Compact; providing purpose, objectives, and definitions; specifying requirements for state participation in the compact and duties of member states; specifying that the compact does not affect an individual's ability to apply for, and a member state's ability to grant, a single-state license pursuant to the laws of that state; providing for recognition of compact privilege in member states; specifying criteria a licensee must meet for compact privilege; providing for the expiration and renewal of compact privilege; specifying that a licensee with compact privilege in a remote state must adhere to the laws and rules of that state; authorizing member states to act on a licensee's compact privilege under certain circumstances; specifying the consequences and parameters of practice for a licensee whose compact privilege has been acted on or whose home state license is encumbered; specifying that a licensee may hold a home state license in only one member state at a time; specifying requirements and procedures for changing a home state license designation; providing for the recognition of the practice of audiology and

speech-language pathology through telehealth in member states; specifying that a licensee must adhere to the laws and rules of the remote state in which he or she provides audiology or speech-language pathology through telehealth; authorizing active duty military personnel and their spouses to keep their home state designation during active duty; specifying how such individual may subsequently change his or her home state license designation; authorizing member states to take adverse actions against licensees and issue subpoenas for hearings and investigations under certain circumstances; providing requirements and procedures for such adverse action; authorizing member states to engage in joint investigations under certain circumstances; providing that a licensee's compact privilege must be deactivated in all member states for the duration of an encumbrance imposed by the licensee's home state; providing for notice to the data system and the licensee's home state of any adverse action taken against a licensee; establishing the Audiology and Speech-language Pathology Interstate Compact Commission; providing for jurisdiction and venue for court proceedings; providing for membership and powers of the commission; specifying powers and duties of the commission's executive committee;

providing for the financing of the commission; providing specified individuals immunity from civil liability under certain circumstances; providing exceptions; requiring the commission to defend the specified individuals in civil actions under certain circumstances; requiring the commission to indemnify and hold harmless specified individuals for any settlement or judgment obtained in such actions under certain circumstances; providing for the development of the data system, reporting procedures, and the exchange of specified information between member states; requiring the commission to notify member states of any adverse action taken against a licensee or applicant for licensure; authorizing member states to designate as confidential information provided to the data system; requiring the commission to remove information from the data system under certain circumstances; providing rulemaking procedures for the commission; providing for member state enforcement of the compact; authorizing the commission to receive notice of process, and have standing to intervene, in certain proceedings; rendering certain judgments and orders void as to the commission, the compact, or commission rules under certain circumstances; providing for defaults and termination of compact

membership; providing procedures for the resolution of certain disputes; providing for commission enforcement of the compact; providing for remedies; providing for implementation of, withdrawal from, and amendment to the compact; specifying that licensees practicing in a remote state under the compact must adhere to the laws and rules of that state; specifying that the compact, commission rules, and commission actions are binding on member states; providing construction; providing for severability; specifying that the provisions of the Physical Therapy Licensure Compact do not authorize the Department of Health or the Board of Physical Therapy to collect a compact privilege fee, but rather state that fees of that kind are allowable under the compact; authorizing the Department of Health or the Board of Speech-Language Pathology and Audiology to collect a compact privilege fee; amending ss. 486.028, 486.031, 486.081, 486.102, 486.107, and 490.006, F.S.; exempting from licensure requirements physical therapists and physical therapist assistants who are practicing in this state pursuant to a compact privilege under the compact; revising licensure requirements to include licensure by endorsement to practice as a physical therapist; creating s. 486.112, F.S.; creating the Physical Therapy Licensure Compact;

providing a purpose and objectives of the compact; providing definitions; specifying requirements for state participation in the compact; authorizing member states to obtain biometric-based information from and conduct criminal background checks on licensees applying for a compact privilege; requiring member states to grant the compact privilege to licensees who meet specified criteria; specifying criteria licensees must meet to exercise the compact privilege under the compact; providing for the expiration of the compact privilege; requiring licensees practicing in a remote state under the compact privilege to comply with the laws and rules of that state; subjecting licensees to the regulatory authority of remote states where they practice under the compact privilege; providing for disciplinary action; specifying circumstances under which licensees are ineligible for a compact privilege; specifying conditions that a licensee must meet to regain his or her compact privilege after an adverse action; specifying locations active duty military personnel and their spouses may use to designate their home state for purposes of the compact; providing that only a home state may impose adverse action against a license issued by that state; authorizing home states to take adverse action based

on investigative information of a remote state, subject to certain requirements; directing member states that use alternative programs in lieu of discipline to require the licensee to agree not to practice in other member states while participating in the program, unless authorized by the member state; authorizing member states to investigate violations by licensees in other member states; authorizing member states to take adverse action against compact privileges issued in their respective states; providing for joint investigations of licensees under the compact; establishing the Physical Therapy Compact Commission; providing for the venue and jurisdiction for court proceedings by or against the commission; providing construction; providing for commission membership, voting, and meetings; authorizing the commission to convene closed, nonpublic meetings under certain circumstances; specifying duties and powers of the commission; providing for membership and duties of the executive board of the commission; providing for financing of the commission; providing for qualified immunity, defense, and indemnification of the commission; requiring the commission to develop and maintain a coordinated database and reporting system for certain information about licensees under the

compact; requiring member states to submit specified information to the system; requiring that information contained in the system be available only to member states; requiring the commission to promptly notify all member states of reported adverse action taken against licensees or applicants for licensure; authorizing member states to designate reported information as exempt from public disclosure; providing for the removal of submitted information from the system under certain circumstances; providing for commission rulemaking; providing construction; providing for state enforcement of the compact; providing for the default and termination of compact membership; providing for appeals and costs; providing procedures for the resolution of certain disputes; providing for enforcement against a defaulting state; providing construction; providing for implementation and administration of the compact and associated rules; providing that compact states that join after initial adoption of the commission's rules are subject to such rules; specifying procedures for compact states to withdraw from the compact; providing construction; providing for amendment of the compact; providing construction and severability; specifying that the provisions of the Physical Therapy Licensure

Compact do not authorize the Department of Health or the Board of Physical Therapy to collect a compact privilege fee, but rather state that fees of that kind are allowable under the compact; amending s. 486.023, F.S.; requiring the Board of Physical Therapy Practice to appoint a person to serve as the state's delegate on the Physical Therapy Compact Commission; amending s. 486.125, F.S.; authorizing the board to take adverse action against the compact privilege of physical therapists and physical therapist assistants for specified prohibited acts; amending s. 624.27, F.S.; revising the definition of the term "health care provider"; amending s. 95.11, F.S.; establishing a 3-year statute of limitations for an action to collect medical debt for services rendered by a health care provider or facility; creating s. 222.26, F.S.; providing additional personal property exemptions from legal process for medical debts resulting from services provided in certain licensed facilities; creating s. 627.446, F.S.; providing a definition; requiring each health insurer to provide an insured with an advanced explanation of benefits after receiving a patient estimate from a facility for scheduled services; providing requirements for the advanced explanation of benefits; amending s. 627.447,

F.S.; prohibiting a health insurer from disclosing specified information relating to discounted cash prices to certain persons; defining the term "discounted cash price"; amending s. 627.6387, F.S.; revising definitions; requiring, rather than authorizing, a health insurer to offer a shared savings incentive program for specified purposes; requiring a health insurer to notify an insured that participation in such program is voluntary and optional; amending ss. 627.6648 and 641.31076, F.S.; providing that a shared savings incentive offered by a health insurer or health maintenance organization constitutes a medical expense for rate development and rate filing purposes; amending s. 766.1115, F.S.; revising the definition of the term "low-income" for purposes of certain government contracts for health care services; amending s. 768.28, F.S.; designating the state delegates and other members or employees of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-Language Pathology Interstate Compact Commission, and the Physical Therapy Compact Commission as state agents for the purpose of applying sovereign immunity and waivers of sovereign immunity; requiring the commission to pay certain claims or judgments; authorizing the commission to maintain

insurance coverage to pay such claims or judgments; amending s. 1002.32, F.S.; requiring developmental research schools to develop programs for a specified purpose; requiring schools to offer technical assistance to any school district seeking to replicate the school's programs; requiring schools, beginning on a date certain, to annually report to the Legislature on the development of such programs and the results, when available; amending s. 1004.015, F.S.; requiring the Commission for Independent Education and the Independent Colleges and Universities of Florida to annually report specified data for each medical school graduate; amending s. 1009.8962, F.S.; revising the definition of the term "institution" for purposes of the Linking Industry to Nursing Education (LINE) Fund; requiring the Board of Governors and the Department of Education to submit to the Governor and the Legislature a specified report; amending ss. 486.025, 486.0715, and 486.1065, F.S.; conforming cross-references; amending ss. 395.602, 458.316, 458.3165, 468.209, 468.511, 475.01, 475.611, 517.191, and 787.061, F.S.; conforming provisions to changes made by the act; providing appropriations; providing a directive to the department; providing effective dates.

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

Section 1. Paragraph (f) of subsection (3) of section 381.4018, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

381.4018 Physician workforce assessment and development.—

(3) GENERAL FUNCTIONS.—The department shall maximize the use of existing programs under the jurisdiction of the department and other state agencies and coordinate governmental and nongovernmental stakeholders and resources in order to develop a state strategic plan and assess the implementation of such strategic plan. In developing the state strategic plan, the department shall:

(f) Develop strategies to maximize federal and state programs that provide for the use of incentives to attract physicians to this state or retain physicians within the state. Such strategies should explore and maximize federal-state partnerships that provide incentives for physicians to practice in federally designated shortage areas, in otherwise medically underserved areas, or in rural areas. Strategies shall also consider the use of state programs, such as the Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program pursuant to s. 381.402 ~~s. 1009.65~~, which provide for education loan repayment or loan forgiveness and

provide monetary incentives for physicians to relocate to underserved areas of the state.

The department may adopt rules to implement this subsection, including rules that establish guidelines to implement the federal Conrad 30 Waiver Program created under s. 214(l) of the Immigration and Nationality Act.

(5) DATA COLLECTION.—To facilitate ongoing monitoring and analyses of the state's graduate medical education system, the department shall require physician licensees to provide the following information:

(a) For each licensed resident and physician, the state in which he or she attended medical school, the state in which he or she was trained in graduate medical education programs, his or her graduate medical education specialty, and the beginning date and completion date of his or her graduate medical education training.

(b) For each licensed resident and physician who received graduate medical education in Florida, the name of the medical school, accredited program, and sponsoring institution.

The department shall collect and compile the information required by this subsection in consultation with the Office of Program Policy Analysis and Government Accountability.

Section 2. Section 381.4019, Florida Statutes, is amended

to read:

381.4019 Dental Student Loan Repayment Program.—The Dental Student Loan Repayment Program is established to support the state Medicaid program and promote access to dental care by supporting qualified dentists and dental hygienists who treat medically underserved populations in dental health professional shortage areas or medically underserved areas.

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

(a) "Dental health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

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

(c) "Free clinic" means a provider that meets the description of a clinic specified in s. 766.1115(3)(d)14.

(d) ~~(c)~~ "Loan program" means the Dental Student Loan Repayment Program.

(e) ~~(d)~~ "Medically underserved area" means a geographic area, an area having a special population, or a facility which is designated by department rule as a health professional shortage area as defined by federal regulation and which has a shortage of dental health professionals who serve Medicaid recipients and other low-income patients.

(f) ~~(e)~~ "Public health program" means a county health department, the Children's Medical Services program, a federally

funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department.

(2) The department shall establish a dental student loan repayment program to benefit Florida-licensed dentists and dental hygienists who:

(a) Demonstrate, as required by department rule, active employment in a public health program or private practice that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or a medically underserved area.

(b) Volunteer 25 hours per year providing dental services in a free clinic that is located in a dental health professional shortage area or a medically underserved area or through another volunteer program operated by the state pursuant to part IV of chapter 110. In order to meet the requirements of this paragraph, the volunteer hours must be verifiable in a manner determined by the department.

(3) The department shall award funds from the loan program to repay the student loans of a dentist or dental hygienist who meets the requirements of subsection (2).

(a) An award shall be 20 percent of a dentist's or dental hygienist's principal loan amount at the time he or she applies for the program but may not exceed $50,000 per year per eligible dentist or $7,500 per year per eligible dental hygienist.

(b) Only loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses may be covered.

(c) All repayments are contingent upon continued proof of eligibility and must be made directly to the holder of the loan. The state bears no responsibility for the collection of any interest charges or other remaining balances.

(d) A dentist or dental hygienist may receive funds under the loan program for at least 1 year, up to a maximum of 5 years.

~~(e) The department shall limit the number of new dentists participating in the loan program to not more than 10 per fiscal year.~~

(4) A dentist or dental hygienist is not ~~is no longer~~ eligible to receive funds under the loan program if the dentist or dental hygienist:

(a) Is no longer employed by a public health program or private practice that meets the requirements of subsection (2) or does not verify, in a manner determined by the department, that he or she has volunteered his or her dental services for the required number of hours.

(b) Ceases to participate in the Florida Medicaid program.

(c) Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of s. 466.028.

(5) A dentist or dental hygienist who receives payment

under the program shall furnish information requested by the department for the purpose of the department's duties under s. 381.4021.

(6) ~~(5)~~ The department shall adopt rules to administer the loan program.

(7) ~~(6)~~ Implementation of the loan program is subject to legislative appropriation.

(8) The Agency for Health Care Administration shall seek federal authority to use Title XIX matching funds for this program.

(9) This section is repealed on July 1, 2034.

Section 3. Section 1009.65, Florida Statutes, is amended, transferred, and renumbered as section 381.402, Florida Statutes, and amended, to read:

381.402 ~~1009.65~~ Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program.—

(1) To support the state Medicaid program and to encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel, there is established the Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program. The function of the program is to make payments that offset loans and educational expenses incurred by students for studies leading to a medical or nursing degree, medical or nursing licensure, or advanced practice registered nurse licensure or physician

assistant licensure.

(2) The following licensed or certified health care practitioners ~~professionals~~ are eligible to participate in the ~~this~~ program:

(a) Medical doctors and doctors of osteopathic medicine practicing in ~~with~~ primary care specialties.~~, doctors of osteopathic medicine with primary care specialties~~

(b) Advanced practice registered nurses practicing in primary care specialties~~, physician assistants, licensed practical nurses and registered nurses, and advanced practice registered nurses with primary care specialties such as certified nurse midwives~~.

(c) Physician assistants.

(d) Mental health professionals, including licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists.

(e) Licensed practical nurses and registered nurses.

Primary care ~~medical~~ specialties for physicians include obstetrics, gynecology, general and family practice, geriatrics, internal medicine, pediatrics, psychiatry, and other specialties that ~~which~~ may be identified by the Department of Health. Primary care specialties for advanced practice registered nurses include family practice, general pediatrics, general internal

medicine, midwifery, and psychiatric nursing.

(3) From the funds available, the Department of Health shall make payments as follows:

(a)~~1.~~ For a 4-year period of continued proof of practice in a setting specified in paragraph (b), up to $150,000 for physicians, up to $90,000 for advanced practice registered nurses registered to engage in autonomous practice under s. 464.0123, up to $75,000 for advanced practice registered nurses, physician assistants, and mental health professionals, and up to $45,000 ~~up to $4,000 per year~~ for licensed practical nurses and registered nurses. Each practitioner is eligible to receive an award for only one 4-year period of continued proof of practice. At the end of each year that a practitioner participates in the program, the department shall award 25 percent of a practitioner's principal loan amount at the time he or she applied for the program~~, up to $10,000 per year for advanced practice registered nurses and physician assistants, and up to $20,000 per year for physicians~~. Penalties for noncompliance are ~~shall be~~ the same as those in the National Health Services Corps Loan Repayment Program. Educational expenses include costs for tuition, matriculation, registration, books, laboratory and other fees, other educational costs, and reasonable living expenses as determined by the Department of Health.

(b)~~2.~~ All payments are contingent on continued proof of:

1.a. Primary care practice in a rural hospital as ~~an area~~

defined in s. 395.602(2)(b)~~,~~ or an underserved area designated by the Department of Health, provided the practitioner accepts Medicaid reimbursement if eligible for such reimbursement; or

b. For practitioners other than physicians and advanced practice registered nurses, practice in other settings, including, but not limited to, a nursing home facility as defined in s. 400.021, a home health agency as defined in s. 400.462, or an intermediate care facility for the developmentally disabled as defined in s. 400.960. Any such setting must be located in, or serve residents or patients in, an underserved area designated by the Department of Health and must provide services to Medicaid patients.

2. Providing 25 hours annually of volunteer primary care services in a free clinic as specified in s. 766.1115(3)(d)14. or through another volunteer program operated by the state pursuant to part IV of chapter 110. In order to meet the requirements of this subparagraph, the volunteer hours must be verifiable in a manner determined by the department.

(c) Correctional facilities, state hospitals, and other state institutions that employ medical personnel must ~~shall~~ be designated by the Department of Health as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

~~(b) Advanced practice registered nurses registered to~~

~~engage in autonomous practice under s. 464.0123 and practicing in the primary care specialties of family medicine, general pediatrics, general internal medicine, or midwifery. From the funds available, the Department of Health shall make payments of up to $15,000 per year to advanced practice registered nurses registered under s. 464.0123 who demonstrate, as required by department rule, active employment providing primary care services in a public health program, an independent practice, or a group practice that serves Medicaid recipients and other low-income patients and that is located in a primary care health professional shortage area. Only loans to pay the costs of tuition, books, medical equipment and supplies, uniforms, and living expenses may be covered. For the purposes of this paragraph:~~

~~1. "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration or a rural area as defined by the Federal Office of Rural Health Policy.~~

~~2. "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or any other publicly funded or nonprofit health care program designated by the department.~~

(4) ~~(2)~~ The Department of Health may use funds appropriated for the ~~Medical Education Reimbursement and Loan Repayment~~ program as matching funds for federal loan repayment programs such as the National Health Service Corps State Loan Repayment Program.

(5) A health care practitioner who receives payment under the program shall furnish information requested by the department for the purpose of the department's duties under s. 381.4021.

(6) ~~(3)~~ The Department of Health may adopt any rules necessary for the administration of the ~~Medical Education Reimbursement and Loan Repayment~~ program. The department may also solicit technical advice regarding conduct of the program from the Department of Education and Florida universities and Florida College System institutions. The Department of Health shall submit a budget request for an amount sufficient to fund medical education reimbursement, loan repayments, and program administration.

(7) The Agency for Health Care Administration shall seek federal authority to use Title XIX matching funds for this program.

(8) This section is repealed on July 1, 2034.

Section 4. Section 381.4021, Florida Statutes, is created to read:

381.4021 Student loan repayment programs reporting.—

(1) Beginning July 1, 2024, the department shall provide to the Governor, the President of the Senate, and the Speaker of the House of Representatives an annual report for the student loan repayment programs established in ss. 381.4019 and 381.402, which, at a minimum, details all of the following:

(a) The number of applicants for loan repayment.

(b) The number of loan payments made under each program.

(c) The amounts for each loan payment made.

(d) The type of practitioner to whom each loan payment was made.

(e) The number of loan payments each practitioner has received under either program.

(f) The practice setting in which each practitioner who received a loan payment practices.

(2)(a) The department shall contract with an independent third party to develop and conduct a design study to evaluate the impact of the student loan repayment programs established in ss. 381.4019 and 381.402, including, but not limited to, the effectiveness of the programs in recruiting and retaining health care professionals in geographic and practice areas experiencing shortages. The department shall begin collecting data for the study by January 1, 2025, and shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives the results of the study by January 1, 2030.

(b) The department shall participate in a provider

retention and information system management multistate collaborative that collects data to measure outcomes of education debt support-for-service programs.

(3) This section is repealed on July 1, 2034.

Section 5. Section 381.9855, Florida Statutes, is created to read:

381.9855 Health care screening and services grant program; portal.—

(1)(a) The Department of Health shall implement a health care screening and services grant program. The purpose of the program is to expand access to no-cost health care screenings or services for the general public facilitated by nonprofit entities. The department shall do all of the following:

1. Publicize the availability of funds and enlist the aid of county health departments for outreach to potential applicants at the local level.

2. Establish an application process for submitting a grant proposal and eligibility criteria for applicants.

3. Develop guidelines a grant recipient must follow for the expenditure of grant funds and uniform data reporting requirements for the purpose of evaluating the performance of grant recipients.

(b) A nonprofit entity may apply for grant funds in order to implement a new health care screening or service program that the entity has not previously implemented.

(c) A nonprofit entity that has previously implemented a specific health care screening or services program at one or more specific locations may apply for grant funds in order to provide the same or similar screenings or services at a new location or through a mobile health clinic or mobile unit in order to expand the program's delivery capabilities.

(d) An entity that receives a grant under this section must:

1. Follow Department of Health guidelines for reporting on expenditure of grant funds and measures to evaluate the effectiveness of the entity's health care screening or services program.

2. Publicize to the general public and encourage the use of the health care screening portal created under subsection (2).

(e) The Department of Health may adopt rules for the implementation of this subsection.

(2)(a) The Department of Health shall create and maintain an Internet-based portal to direct the general public to events, organizations, and venues in this state from which health screenings or services may be obtained at no cost or at a reduced cost and for the purpose of directing a licensed health care practitioner to opportunities for volunteering his or her services to conduct, administer, or facilitate such health screenings or services. The department may contract for the

creation or maintenance of the portal with a third-party vendor.

(b) The portal must be easily accessible by the public, not require a sign up or login, and include the ability for a member of the public to enter his or her address and obtain localized and current data on opportunities for screenings and services and volunteer opportunities for health care practitioners. The portal must include, but is not limited to, all statutorily created screening programs that are funded and operational under the department's authority. The department shall coordinate with county health departments so that the portal includes information on such health screenings and services provided by county health departments or by nonprofit entities in partnership with county health departments.

(c) The department shall include a clear and conspicuous link to the portal on the homepage of its website. The department shall publicize the portal to, and encourage the use of the portal by, the general public and shall enlist the aid of county health departments for such outreach.

Section 6. Section 383.2163, Florida Statutes, is amended to read:

383.2163 Telehealth minority maternity care program. ~~pilot programs.—By July 1, 2022~~, The department shall establish a statewide telehealth minority maternity care ~~pilot~~ program that ~~in Duval County and Orange County which~~ uses telehealth to expand the capacity for positive maternal health outcomes in

racial and ethnic minority populations. The department shall direct and assist ~~the~~ county health departments ~~in Duval County and Orange County~~ to implement the program ~~programs~~.

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

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

(b) "Eligible pregnant woman" means a pregnant woman who is receiving, or is eligible to receive, maternal or infant care services from the department under chapter 381 or this chapter.

(c) "Health care practitioner" has the same meaning as in s. 456.001.

(d) "Health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(e) "Indigenous population" means any Indian tribe, band, or nation or other organized group or community of Indians recognized as eligible for services provided to Indians by the United States Secretary of the Interior because of their status as Indians, including any Alaskan native village as defined in 43 U.S.C. s. 1602(c), the Alaska Native Claims Settlement Act, as that definition existed on the effective date of this act.

(f) "Maternal mortality" means a death occurring during pregnancy or the postpartum period which is caused by pregnancy or childbirth complications.

(g) "Medically underserved population" means the

population of an urban or rural area designated by the United States Secretary of Health and Human Services as an area with a shortage of personal health care services or a population group designated by the United States Secretary of Health and Human Services as having a shortage of such services.

(h) "Perinatal professionals" means doulas, personnel from Healthy Start and home visiting programs, childbirth educators, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, and other licensed and nonlicensed professionals who assist women through their prenatal or postpartum periods.

(i) "Postpartum" means the 1-year period beginning on the last day of a woman's pregnancy.

(j) "Severe maternal morbidity" means an unexpected outcome caused by a woman's labor and delivery which results in significant short-term or long-term consequences to the woman's health.

(k) "Technology-enabled collaborative learning and capacity building model" means a distance health care education model that connects health care professionals, particularly specialists, with other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

(2) PURPOSE.—The purpose of the program ~~pilot programs~~ is

to:

(a) Expand the use of technology-enabled collaborative learning and capacity building models to improve maternal health outcomes for the following populations and demographics:

1. Ethnic and minority populations.

2. Health professional shortage areas.

3. Areas with significant racial and ethnic disparities in maternal health outcomes and high rates of adverse maternal health outcomes, including, but not limited to, maternal mortality and severe maternal morbidity.

4. Medically underserved populations.

5. Indigenous populations.

(b) Provide for the adoption of and use of telehealth services that allow for screening and treatment of common pregnancy-related complications, including, but not limited to, anxiety, depression, substance use disorder, hemorrhage, infection, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders relating to pregnancy, diabetes, cerebrovascular accidents, cardiomyopathy, and other cardiovascular conditions.

(3) TELEHEALTH SERVICES AND EDUCATION.—The program ~~pilot programs~~ shall adopt the use of telehealth or coordinate with prenatal home visiting programs to provide all of the following services and education to eligible pregnant women up to the last day of their postpartum periods, as applicable:

(a) Referrals to Healthy Start's coordinated intake and referral program to offer families prenatal home visiting services.

(b) Services and education addressing social determinants of health, including, but not limited to, all of the following:

1. Housing placement options.

2. Transportation services or information on how to access such services.

3. Nutrition counseling.

4. Access to healthy foods.

5. Lactation support.

6. Lead abatement and other efforts to improve air and water quality.

7. Child care options.

8. Car seat installation and training.

9. Wellness and stress management programs.

10. Coordination across safety net and social support services and programs.

(c) Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal and postpartum periods.

(d) For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers.

(e) Tools for prenatal women to conduct key components of

maternal wellness checks, including, but not limited to, all of the following:

1. A device to measure body weight, such as a scale.

2. A device to measure blood pressure which has a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

3. A device to measure blood sugar levels with a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

4. Any other device that the health care practitioner performing wellness checks through telehealth deems necessary.

(4) TRAINING.—The program ~~pilot programs~~ shall provide training to participating health care practitioners and other perinatal professionals on all of the following:

(a) Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers to accessing adequate and competent maternity care.

(b) The use of remote patient monitoring tools for pregnancy-related complications.

(c) How to screen for social determinants of health risks in the prenatal and postpartum periods, such as inadequate housing, lack of access to nutritional foods, environmental

risks, transportation barriers, and lack of continuity of care.

(d) Best practices in screening for and, as needed, evaluating and treating maternal mental health conditions and substance use disorders.

(e) Information collection, recording, and evaluation activities to:

1. Study the impact of the ~~pilot~~ program;

2. Ensure access to and the quality of care;

3. Evaluate patient outcomes as a result of the ~~pilot~~ program;

4. Measure patient experience; and

5. Identify best practices for the future expansion of the ~~pilot~~ program.

(5) REPORT.—By October 31, 2025, and each October 31 thereafter, the department shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a program report that includes, at a minimum, all of the following for the previous fiscal year:

(a) The total number of clients served and the demographic information for the population served, including race, ethnicity, age, education level, and geographic location.

(b) The total number of screenings performed, by type.

(c) The number of participants identified as having experienced pregnancy-related complications, the number of participants who received treatments for such complications, and

the final outcome of the pregnancy for such participants.

(d) The number of referrals made to the Healthy Start program or other prenatal home visiting programs and the number of participants who subsequently received services from such programs.

(e) The number of referrals made to doulas and other perinatal professionals and the number of participants who subsequently received services from doulas and other perinatal professionals.

(f) The number and types of devices given to participants to conduct maternal wellness checks.

(g) The average length of participation by program participants.

(h) Composite results of a participant survey that measures the participants' experience with the program.

(i) The total number of health care practitioners trained, by provider type and specialty.

(j) The results of a survey of the health care practitioners trained under the program. The survey must address the quality and impact of the training provided, the health care practitioners' experiences using remote patient monitoring tools, the best practices provided in the training, and any suggestions for improvements.

(k) Aggregate data on the maternal and infant health outcomes of program participants.

(1) For the initial report, all available quantifiable data related to the telehealth minority maternity care pilot programs.

(6)~~(5)~~ FUNDING.~~—The pilot programs shall be funded using funds appropriated by the Legislature for the Closing the Gap grant program.~~ The department's Division of Community Health Promotion and Office of Minority Health and Health Equity shall ~~also~~ work in partnership to apply for federal funds that are available to assist the department in accomplishing the program's purpose and successfully implementing the program ~~pilot programs~~.

(7)~~(6)~~ RULES.—The department may adopt rules to implement this section.

Section 7. Subsections (1) through (8), (9), and (10) of section 383.302, Florida Statutes, are renumbered as subsections (2) through (9), (11), and (12), respectively, present subsection (4) is amended, and new subsections (1) and (10) are added to that section, to read:

383.302 Definitions of terms used in ss. 383.30-383.332.—As used in ss. 383.30-383.332, the term:

(1) "Advanced birth center" means a licensed birth center designated as an advanced birth center which may perform trial of labor after cesarean deliveries for screened patients who qualify, planned low-risk cesarean deliveries, and anticipated vaginal deliveries for laboring patients from the beginning of

the 37th week of gestation through the end of the 41st week of gestation.

(5) ~~(4)~~ "Consultant" means a physician licensed pursuant to chapter 458 or chapter 459 who agrees to provide advice and services to a birth center or an advanced birth center and who either:

(a) Is certified or eligible for certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology; ~~,~~ or

(b) Has hospital obstetrical privileges.

(10) "Medical director" means a person who holds an active unrestricted license as a physician under chapter 458 or chapter 459.

Section 8. Section 383.3081, Florida Statutes, is created to read:

383.3081 Advanced birth center designation.—

(1) To be designated as an advanced birth center, a birth center must, in addition to maintaining compliance with all of the requirements under ss. 383.30-383.332 applicable to birth centers and advanced birth centers, meet all of the following criteria:

(a) Be operated and staffed 24 hours per day, 7 days per week.

(b) Employ two medical directors to oversee the activities of the center, one of whom must be a board-certified

obstetrician and one of whom must be a board-certified anesthesiologist.

(c) Have at least one properly equipped, dedicated surgical suite for the performance of cesarean deliveries.

(d) Employ at least one registered nurse and ensure that at least one registered nurse is present in the center at all times and has the ability to stabilize and facilitate the transfer of patients and newborn infants when appropriate.

(e) Enter into a written agreement with a blood bank for emergency blood bank services and have written protocols for the management of obstetrical hemorrhage which include provisions for emergency blood transfusions. If a patient admitted to an advanced birth center receives an emergency blood transfusion at the center, the patient must immediately thereafter be transferred to a hospital for further care.

(f) Meet all standards adopted by rule for birth centers, unless specified otherwise, and advanced birth centers pursuant to s. 383.309.

(g) Comply with the Florida Building Code and Florida Fire Prevention Code standards for ambulatory surgical centers.

(h) Qualify for, enter into, and maintain a Medicaid provider agreement with the agency pursuant to s. 409.907 and provide services to Medicaid recipients according to the terms of the provider agreement.

(2) The agency shall establish by rule a process for

designating a birth center that meets the requirements of this section as an advanced birth center.

Section 9. Subsection (2) of section 383.309, Florida Statutes, is renumbered as subsection (3), and a new subsection (2) is added to that section, to read:

383.309 Minimum standards for birth centers and advanced birth centers; rules and enforcement.—

(2) The standards adopted by rule for designating a birth center as an advanced birth center must, at a minimum, be equivalent to the minimum standards adopted for ambulatory surgical centers pursuant to s. 395.1055 and must include standards for quality of care, blood transfusions, and sanitary conditions for food handling and food service.

Section 10. Section 383.313, Florida Statutes, is amended to read:

383.313 Birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—A birth center may collect specimens for those tests that are requested under protocol. A birth center must obtain and continuously maintain certification by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder in order to perform laboratory tests specified by rule of the agency, and which are appropriate to meet the needs of the patient.

(2) SURGICAL SERVICES.—Except for advanced birth centers authorized to provide surgical services under s. 383.3131, only those surgical procedures that are ~~shall be limited to those~~ normally performed during uncomplicated childbirths, such as episiotomies and repairs, may be performed at a birth center. ~~and shall not include~~ Operative obstetrics or caesarean sections may not be performed at a birth center.

(3) ADMINISTRATION OF ANALGESIA AND ANESTHESIA.—General and conduction anesthesia may not be administered at a birth center. Systemic analgesia may be administered, and local anesthesia for pudendal block and episiotomy repair may be performed if procedures are outlined by the clinical staff and performed by personnel who have the ~~with~~ statutory authority to do so.

(4) INTRAPARTAL USE OF CHEMICAL AGENTS.—Labor may not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor unless prescribed by personnel who have the ~~with~~ statutory authority to do so and unless in connection with and before ~~prior to~~ emergency transport.

Section 11. Section 383.3131, Florida Statutes, is created to read:

383.3131 Advanced birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—An advanced birth center shall

have a clinical laboratory on site. The clinical laboratory must, at a minimum, be capable of providing laboratory testing for hematology, metabolic screening, liver function, and coagulation studies. An advanced birth center may collect specimens for those tests that are requested under protocol. An advanced birth center may perform laboratory tests as defined by rule of the agency. Laboratories located in advanced birth centers must be appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

(2) SURGICAL SERVICES.—In addition to surgical procedures authorized under s. 383.313(2), surgical procedures for low-risk cesarean deliveries and surgical management of immediate complications may also be performed at an advanced birth center. Postpartum sterilization may be performed before discharge of the patient who has given birth during that admission. Circumcisions may be performed before discharge of the newborn infant.

(3) ADMINISTRATION OF ANALGESIA AND ANESTHESIA.—General, conduction, and local anesthesia may be administered at an advanced birth center if administered by personnel who have the statutory authority to do so. All general anesthesia must be administered by an anesthesiologist or a certified registered nurse anesthetist in accordance with s. 464.012. When general

anesthesia is administered, a physician or a certified registered nurse anesthetist must be present in the advanced birth center during the anesthesia and postanesthesia recovery period until the patient is fully alert. Each advanced birth center shall comply with s. 395.0191(2)(b).

(4) INTRAPARTAL USE OF CHEMICAL AGENTS.—Labor may be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor at an advanced birth center if prescribed by personnel who have the statutory authority to do so. Labor may be electively induced beginning at the 39th week of gestation for a patient with a documented Bishop score of 8 or greater.

Section 12. Subsection (3) is added to section 383.315, Florida Statutes, to read:

383.315 Agreements with consultants for advice or services; maintenance.—

(3) An advanced birth center shall employ or maintain an agreement with an obstetrician who must be present in the center at all times during which a patient is in active labor in the center to attend deliveries, available to respond to emergencies, and, when necessary, available to perform cesarean deliveries.

Section 13. Section 383.316, Florida Statutes, is amended to read:

383.316 Transfer and transport of clients to hospitals.—

(1) If unforeseen complications arise during labor, delivery, or postpartum recovery, the client must ~~shall~~ be transferred to a hospital.

(2) Each birth center ~~licensed facility~~ shall make arrangements with a local ambulance service licensed under chapter 401 for the transport of emergency patients to a hospital. Such arrangements must ~~shall~~ be documented in the center's policy and procedures manual ~~of the facility~~ if the birth center does not own or operate a licensed ambulance. The policy and procedures manual ~~shall~~ also must contain specific protocols for the transfer of any patient to a licensed hospital.

(3) Each advanced birth center shall enter into a written transfer agreement with a local hospital licensed under chapter 395 for the transfer and admission of emergency patients to the hospital or a written agreement with an obstetrician who has hospital privileges to provide coverage at all times and who has agreed to accept the transfer of the advanced birth center's patients.

(4) ~~(3)~~ A birth center ~~licensed facility~~ shall identify neonatal-specific transportation services, including ground and air ambulances; list their particular qualifications; and have the telephone numbers for access to these services clearly listed and immediately available.

(5) ~~(4)~~ The birth center shall assess and document ~~Annual~~

~~assessments of~~ the transportation services and transfer protocols annually ~~shall be made and documented~~.

Section 14. Subsections (2) and (3) of section 383.318, Florida Statutes, are renumbered as subsections (3) and (4), respectively, subsection (1) is amended, and a new subsection (2) is added to that section, to read:

383.318 Postpartum care for birth center and advanced birth center clients and infants.—

(1) Except at an advanced birth center that must adhere to the requirements of subsection (2), a mother and her infant must ~~shall~~ be dismissed from a ~~the~~ birth center within 24 hours after the birth of the infant, except in unusual circumstances as defined by rule of the agency. If a mother or an infant is retained at the birth center for more than 24 hours after the birth, a report must ~~shall~~ be filed with the agency within 48 hours after ~~of~~ the birth and must describe ~~describing~~ the circumstances and the reasons for the decision.

(2)(a) A mother and her infant must be dismissed from an advanced birth center within 48 hours after a vaginal delivery or within 72 hours after a delivery by cesarean section, except in unusual circumstances as defined by rule of the agency.

(b) If a mother or an infant is retained at the advanced birth center for more than the timeframes set forth in paragraph (a), a report must be filed with the agency within 48 hours after the scheduled discharge time and must describe the

circumstances and the reasons for the decision.

Section 15. Subsections (5), (31), and (36) of section 394.455, Florida Statutes, are amended to read:

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

(5) "Clinical psychologist" means a person licensed to practice psychology under chapter 490 ~~a psychologist as defined in s. 490.003(7) with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure,~~ or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility under this part.

(31) "Mobile crisis response service" or "mobile response team" means a nonresidential mental and behavioral health crisis service available 24 hours per day, 7 days per week which provides immediate intensive assessments and interventions, including screening for admission into a mental health receiving facility, an addictions receiving facility, or a detoxification facility, for the purpose of identifying appropriate treatment services.

(36) "Psychiatric nurse" means an advanced practice registered nurse licensed under s. 464.012 who has a master's or doctoral degree in psychiatric nursing and~~,~~ holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 1 year ~~2 years~~ of post-master's

clinical experience under the supervision of a physician.

Section 16. Paragraph (c) of subsection (5) of section 394.457, Florida Statutes, is amended to read:

394.457 Operation and administration.—

(5) RULES.—

(c) The department shall adopt rules establishing minimum standards for services provided by a mental health overlay program or a mobile crisis response service. Minimum standards for mobile crisis response services must:

1. Include child, adolescent, and young adult mobile response teams established under s. 394.495(7) and ensure coverage of all counties by these specified teams.

2. Create a structure for general mobile response teams which focuses on emergency room diversion and the reduction of involuntary commitment under this chapter. The structure must require, but need not be limited to, the following:

a. Triage and rapid crisis intervention within 60 minutes.

b. Provision of and referral to evidence-based services that are responsive to the needs of the individual and the individual's family.

c. Screening, assessment, early identification, and care coordination.

d. Followup at 90 and 180 days to gather outcome data on a mobile crisis response encounter to determine efficacy of the mobile crisis response service.

Section 17. Subsections (1) and (3) of section 394.4598, Florida Statutes, are amended to read:

394.4598 Guardian advocate.—

(1) The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and had a guardian with the authority to consent to mental health treatment appointed, the court must ~~it shall~~ appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court must ~~shall~~ appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding must ~~shall~~ be recorded, either electronically or stenographically, and testimony must ~~shall~~ be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in s. 394.4655 or s. 394.467, must testify. A guardian advocate must meet the qualifications of a guardian contained in part IV of chapter 744, except that a professional referred to in this part, an employee of the facility providing direct services to the

patient under this part, a departmental employee, a facility administrator, or member of the Florida local advocacy council shall not be appointed. A person ~~who is~~ appointed as a guardian advocate must agree to the appointment.

(3) A facility requesting appointment of a guardian advocate must, before ~~prior to~~ the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decisionmaking. Before asking a guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. Before giving consent to treatment, the guardian advocate must meet and talk with the patient and the patient's physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist in person, if at all possible, and by telephone, if not. The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.

Section 18. Subsection (11) of section 394.4615, Florida

Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(11) Patients must ~~shall~~ have reasonable access to their clinical records, unless such access is determined by the patient's physician or the patient's psychiatric nurse to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction must ~~shall~~ be given to the patient and the patient's guardian, guardian advocate, attorney, and representative. In addition, the restriction must ~~shall~~ be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record expires ~~shall expire~~ after 7 days but may be renewed, after review, for subsequent 7-day periods.

Section 19. Paragraph (f) of subsection (1) and subsection (5) of section 394.4625, Florida Statutes, are amended to read:

394.4625 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(f) Within 24 hours after admission of a voluntary patient, the treating ~~admitting~~ physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility must ~~shall~~ either

discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

(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, clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology, or 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 ~~shall~~ be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written 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 20. Paragraph (f) of subsection (2) of section 394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(f) A patient must ~~shall~~ be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist if the physician or psychiatric nurse determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology or, if the receiving facility is owned or operated by a hospital, health system, or nationally accredited community mental health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. The release may be approved through telehealth.

Section 21. Paragraphs (a) and (b) of subsection (3), paragraph (b) of subsection (7), and paragraph (a) of subsection (8) of section 394.4655, Florida Statutes, are amended to read:

394.4655 Involuntary outpatient services.—

(3) INVOLUNTARY OUTPATIENT SERVICES.—

(a)1. A patient who is being recommended for involuntary outpatient services by the administrator of the facility where the patient has been examined may be retained by the facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience ~~or~~ another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, a clinical psychologist, or by a psychiatric nurse. Any second

opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate that authorizes the facility to retain the patient pending completion of a hearing. The certificate must be made a part of the patient's clinical record.

2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services. Before filing a petition for involuntary outpatient services, the administrator of the facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.

3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary

outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.

(b) If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient services, the administrator of the facility may, before the expiration of the period during which the facility is authorized to retain the patient, recommend involuntary outpatient services. The recommendation must be supported by the opinion of a

psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience, ~~or~~ another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, a clinical psychologist, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate, and the certificate must be made a part of the patient's clinical record.

(7) HEARING ON INVOLUNTARY OUTPATIENT SERVICES.—

(b)1. If the court concludes that the patient meets the criteria for involuntary outpatient services pursuant to subsection (2), the court must ~~shall~~ issue an order for involuntary outpatient services. The court order must ~~shall~~ be

for a period of up to 90 days. The order must specify the nature and extent of the patient's mental illness. The order of the court and the treatment plan must be made part of the patient's clinical record. The service provider shall discharge a patient from involuntary outpatient services when the order expires or any time the patient no longer meets the criteria for involuntary placement. Upon discharge, the service provider shall send a certificate of discharge to the court.

2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court. The order may be submitted electronically through existing data systems. After the order for involuntary services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of

the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).

3. If, in the clinical judgment of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician or psychiatric nurse, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the facility. The involuntary outpatient services order must ~~shall~~ remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the

patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).

(8) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT SERVICES.—

(a)1. If the person continues to meet the criteria for involuntary outpatient services, the service provider must ~~shall~~, at least 10 days before the expiration of the period during which the treatment is ordered for the person, file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.

2. The existing involuntary outpatient services order remains in effect until disposition on the petition for continued involuntary outpatient services.

3. A certificate must ~~shall~~ be attached to the petition which includes a statement from the person's physician or clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology 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.

4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient's guardian advocate, if applicable. When the

petition has been filed, the clerk of the court shall provide copies of the certificate 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.

Section 22. Subsection (2) of section 394.467, Florida Statutes, is amended to read:

394.467 Involuntary inpatient placement.—

(2) ADMISSION TO A TREATMENT FACILITY.—A patient may be retained by a facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience, ~~or~~ another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. However, if the administrator certifies that a psychiatrist or clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in

diagnosis and treatment of mental illness, a clinical psychologist, or ~~by~~ a psychiatric nurse. Any opinion authorized in this subsection may be conducted through a face-to-face examination, in person, or by electronic means. Such recommendation must ~~shall~~ be entered on a petition for involuntary inpatient placement certificate that authorizes the facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

Section 23. Subsection (1) of section 394.4781, Florida Statutes, is amended to read:

394.4781 Residential care for psychotic and emotionally disturbed children.—

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

(a) ~~(b)~~ "Department" means the Department of Children and Families.

(b) ~~(a)~~ "Psychotic or severely emotionally disturbed child" means a child so diagnosed by a psychiatrist or a clinical psychologist with at least 3 years of postdoctoral experience in the practice of clinical psychology, who must have ~~who has~~ specialty training and experience with children. Such a severely emotionally disturbed child or psychotic child shall be considered by this diagnosis to benefit by and require residential care as contemplated by this section.

Section 24. Subsection (2) of section 394.4785, Florida Statutes, is amended to read:

394.4785 Children and adolescents; admission and placement in mental facilities.—

(2) A person under the age of 14 who is admitted to any hospital licensed pursuant to chapter 395 may not be admitted to a bed in a room or ward with an adult patient in a mental health unit or share common areas with an adult patient in a mental health unit. However, a person 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician or psychiatric nurse documents in the case record that such placement is medically indicated or for reasons of safety. Such placement must ~~shall~~ be reviewed by the attending physician or a designee or on-call physician each day and documented in the case record.

Section 25. Effective upon this act becoming a law, the Agency for Health Care Administration shall seek federal approval for coverage and reimbursement authority for mobile crisis response services pursuant to 42 U.S.C. s. 1396w-6. The Department of Children and Families must coordinate with the Agency for Health Care Administration to educate contracted providers of child, adolescent, and young adult mobile response team services on the process to enroll as a Medicaid provider, encourage and incentivize enrollment as a Medicaid provider, and reduce barriers to maximizing federal reimbursement for community-based mobile crisis response services.

Section 26. Paragraph (a) of subsection (1) of section

394.875, Florida Statutes, is amended to read:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician, ~~or~~ psychiatrist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds.

Section 27. Paragraphs (i) and (j) are added to subsection (1) of section 395.1055, Florida Statutes, 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:

(i) A hospital does not accept any payment from a medical

school in exchange for, or directly or indirectly related to, allowing students from the medical school to obtain clinical hours or instruction at that hospital.

(j) Each hospital with an emergency department, including a hospital-based off-campus emergency department, submits to the agency for approval a plan for assisting a patient with gaining access to appropriate care settings when the patient either presents at the emergency department with nonemergent health care needs or indicates, when receiving triage or treatment at the hospital, that the patient lacks regular access to primary care, in order to divert such patient from presenting at the emergency department for future nonemergent care. Effective July 1, 2025, such emergency department diversion plan must be approved by the agency before the hospital may receive initial licensure or licensure renewal occurring after that date. A hospital with an approved emergency department diversion plan must submit data to the agency demonstrating the effectiveness of the hospital's plan on an annual basis and must update the plan as necessary, or as directed by the agency, before each licensure renewal. An emergency department diversion plan must include at least one of the following:

1. A partnership agreement with one or more nearby federally qualified health centers or other primary care settings. The goals of such partnership agreement must include, but need not be limited to, identifying patients who present at

the emergency department for nonemergent care, care that would be best provided in a primary care setting, or emergency care that could potentially have been avoided through the regular provision of primary care; and establishing a relationship between the patient and the federally qualified health center or other primary care setting so that the patient develops a medical home at such setting for nonemergent and preventative health care services.

2. The establishment, construction, and operation of a hospital-owned urgent care center adjacent to the hospital emergency department location or an agreement with an urgent care center within 3 miles of the emergency department if located in an urban area as defined in s. 189.041(1)(b) and within 10 miles of the emergency department if located in a rural community as defined in s. 288.0656(2). Under the hospital's emergency department diversion plan, and as appropriate for the patients' needs, the hospital shall seek to divert to the urgent care center those patients who present at the emergency department needing nonemergent health care services and subsequently assist the patient in obtaining primary care.

For such patients who are enrolled in the Medicaid program and are members of a Medicaid managed care plan, the hospital's emergency department diversion plan must include outreach to the

patients' Medicaid managed care plan and coordination with the managed care plan for establishing a relationship between the patient and a primary care setting as appropriate for the patient, which may include a federally qualified health center or other primary care setting with which the hospital has a partnership agreement. For such Medicaid enrollee, the agency shall establish a process for hospitals to share updated contact information for such patients, if in the hospital's possession, with the patient's managed care plan.

Section 28. Paragraphs (b), (c), and (d) of subsection (1) of section 395.301, Florida Statutes, are redesignated as paragraphs (c), (d), and (e), respectively, subsection (6) is renumbered as subsection (8), present paragraph (b) of subsection (1) is amended, a new paragraph (b) is added to subsection (1), and a new subsection (6) and subsection (7) are added to that section, to read:

395.301 Price transparency; itemized patient statement or bill; patient admission status notification.—

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as

state facilities are exempt from this subsection.

(b) Each licensed facility shall post on its website a consumer-friendly list of standard charges for at least 300 shoppable health care services. If a facility provides fewer than 300 distinct shoppable health care services, it shall make available on its website the standard charges for each service it provides. As used in this paragraph, the term:

1. "Shoppable health care service" means a service that can be scheduled by a healthcare consumer in advance. The term includes, but is not limited to, the services described in s. 627.6387(2)(e) and any services defined in regulations or guidance issued by the United States Department of Health and Human Services.

2. "Standard charge" has the same meaning as that term is defined in regulations or guidance issued by the United States Department of Health and Human Services for purposes of hospital price transparency.

(c)~~(b)~~1. ~~Upon request, and~~ Before providing any nonemergency medical services, each licensed facility shall provide in writing or by electronic means a good faith estimate of reasonably anticipated charges by the facility for the treatment of a ~~the~~ patient's or prospective patient's specific condition. Such estimate must be provided to the patient or prospective patient upon scheduling a medical service. The facility ~~must provide the estimate to the patient or prospective~~

~~patient within 7 business days after the receipt of the request~~ ~~and~~ is not required to adjust the estimate for any potential insurance coverage. The facility must provide the estimate to the patient's health insurer, as defined in s. 627.446(1), and the patient at least 3 business days before a service is to be provided, but no later than 1 business day after the service is scheduled or, in the case of a service scheduled at least 10 business days in advance, no later than 3 business days after the service is scheduled. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c) unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient. The facility shall inform the patient or prospective patient that he or she may contact his or her health insurer ~~or health maintenance organization~~ for additional information concerning cost-sharing responsibilities.

2. In the estimate, the facility shall provide to the patient or prospective patient information on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.

3. The estimate shall clearly identify any facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the

estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.

4. ~~Upon request,~~ The facility shall notify the patient or prospective patient of any revision to the estimate.

5. In the estimate, the facility must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.

~~6. The facility shall take action to educate the public that such estimates are available upon request.~~

6.~~7.~~ Failure to timely provide the estimate pursuant to this paragraph shall result in a daily fine of $1,000 until the estimate is provided to the patient or prospective patient and the health insurer. The total fine per patient estimate may not exceed $10,000.

~~The provision of an estimate does not preclude the actual charges from exceeding the estimate.~~

(6) Each facility shall establish an internal process for reviewing and responding to grievances from patients. Such process must allow patients to dispute charges that appear on the patient's itemized statement or bill. The facility shall prominently post on its website and indicate in bold print on

each itemized statement or bill the instructions for initiating a grievance and the direct contact information required to initiate the grievance process. The facility must provide an initial response to a patient grievance within 7 business days after the patient formally files a grievance disputing all or a portion of an itemized statement or bill.

(7) Each licensed facility shall disclose to a patient, prospective patient, or a patient's legal guardian whether a cost-sharing obligation for a particular covered health care service or item exceeds the charge that applies to an individual who pays cash or the cash equivalent, for the same health care service or item in the absence of health insurance coverage. Failure to provide a disclosure in compliance with this subsection may result in a fine not to exceed $500 per incident.

Section 29. Section 395.3011, Florida Statutes, is created to read:

395.3011 Billing and collection activities.—

(1) As used in this section, the term "extraordinary collection action" means any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the facility's financial assistance policy:

(a) Selling the individual's debt to another party.

(b) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

(c) Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the facility's financial assistance policy.

(d) Actions that require a legal or judicial process, including, but not limited to:

1. Placing a lien on the individual's property;

2. Foreclosing on the individual's real property;

3. Attaching or seizing the individual's bank account or any other personal property;

4. Commencing a civil action against the individual;

5. Causing the individual's arrest; or

6. Garnishing the individual's wages.

(2) A facility may not engage in an extraordinary collection action against an individual to obtain payment for services:

(a) Before the facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided and, if eligible, before a decision is made by the facility on the patient's application for such financial assistance.

(b) Before the facility has provided the individual with an itemized statement or bill.

(c) During an ongoing grievance process as described in s. 395.301(6) or an ongoing appeal of a claim adjudication.

(d) Before billing any applicable insurer and allowing the insurer to adjudicate a claim.

(e) For 30 days after notifying the patient in writing, by certified mail, or by other traceable delivery method, that a collection action will commence absent additional action by the patient.

(f) While the individual:

1. Negotiates in good faith the final amount of a bill for services rendered; or

2. Complies with all terms of a payment plan with the facility.

Section 30. Subsections (5) and (6) of section 408.051, Florida Statutes, are renumbered as subsections (6) and (7), respectively, and a new subsection (5) is added to that section, to read:

408.051 Florida Electronic Health Records Exchange Act.—

(5) HOSPITAL DATA.—A hospital as defined in s. 395.002(12) which maintains certified electronic health record technology must make available admission, transfer, and discharge data to the agency's Florida Health Information Exchange program for the purpose of supporting public health data registries and patient care coordination. The agency may adopt rules to implement this subsection.

Section 31. Subsection (8) of section 409.909, Florida Statutes, is renumbered as subsection (10), paragraph (a) of

subsection (6) is amended, and a new subsection (8) and subsection (9) are added to that section, to read:

409.909 Statewide Medicaid Residency Program.—

(6) The Slots for Doctors Program is established to address the physician workforce shortage by increasing the supply of highly trained physicians through the creation of new resident positions, which will increase access to care and improve health outcomes for Medicaid recipients.

(a)1. Notwithstanding subsection (4), the agency shall annually allocate $100,000 to hospitals and qualifying institutions for each newly created resident position that is first filled on or after June 1, 2023, and filled thereafter, and that is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit.

2. Notwithstanding the requirement that a new resident position be created to receive funding under this subsection, the agency may allocate $100,000 to hospitals and qualifying institutions, pursuant to subparagraph 1., for up to 200 resident positions that existed before July 1, 2023, if such resident position:

a. Is in a physician specialty or subspecialty experiencing a statewide supply-and-demand deficit.

b. Has been unfilled for a period of 3 or more years.

c. Is subsequently filled on or after June 1, 2024, and remains filled thereafter.

d. Is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program.

3. If applications for resident positions under this paragraph exceed the number of authorized resident positions or the available funding allocated, the agency shall prioritize applications for resident positions that are in a primary care specialty as specified in paragraph (2)(a).

(8) A hospital or qualifying institution that receives state funds, including, but not limited to, intergovernmental transfers, for a graduate medical education program under any of the programs established under this chapter or under the General Appropriations Act, must annually report data to the agency in a format established by the agency. To facilitate ongoing analysis of the performance of the state's graduate medical education system, the agency shall consult with the Office of Program Policy Analysis and Government Accountability regarding the content of the data reported, the manner of reporting, and compilation of the data by the agency.

(a) Hospitals and qualifying institutions must report, at a minimum, the following:

1. For each program, the sponsoring institution, the program level, specialty and subspecialty as applicable, the number of approved and filled positions, and the location. As used in this section, the term "sponsoring institution" means an organization that oversees, supports, and administers one or more resident positions.

2. For each position, the year the position was created, whether the position is currently filled and whether there has been any period of time when the position was not filled, each state and federal funding source used to create or maintain the position, and the general purpose for which the funds were used.

3. For each filled position, the current program year of the resident who is filling the position, the specialty or subspecialty for which the position is accredited, and whether the position is a fellowship position.

4. For each sponsoring institution, the number of programs, number of approved and filled positions, and sponsoring institution location.

(b) Specific to funds allocated pursuant to subsection (5) on or after July 1, 2021, the data must include, but is not limited to, all of the following:

1. The date on which the hospital or qualifying institution applied for funds under the program.

2. The date on which the position funded by the program became accredited.

3. The date on which the position was first filled and whether it has remained filled.

4. The specialty of the position created.

(c) Beginning on July 1, 2025, each hospital or qualifying institution shall annually produce detailed financial records no later than 30 days after the end of its fiscal year, detailing the manner in which state funds allocated under this section were expended. This requirement does not apply to funds allocated before July 1, 2025. The agency may also require that any hospital or qualifying institution submit to an audit of its financial records related to funds allocated under this section after July 1, 2025.

(d) If a hospital or qualifying institution fails to produce records as required by this section, such hospital or qualifying institution is no longer eligible to participate in any program established under this section until the hospital or qualifying institution has met the agency's requirements for producing the required records.

(e) Upon completion of a residency, each hospital or qualifying institution must request that the resident fill out an exit survey on a form developed by the agency. The completed exit surveys must be provided to the agency annually. The exit survey must include, but need not be limited to, questions on all of the following:

1. Whether the exiting resident has procured employment.

2. Whether the exiting resident plans to leave the state and, if so, for which reasons.

3. Where and in which specialty the exiting resident intends to practice.

4. Whether the exiting resident envisions himself or herself working in the medical field as a long-term career.

(9) The Graduate Medical Education Committee is created within the agency.

(a) The committee shall be composed of the following members:

1. Three deans, or the deans' designees, from medical schools in the state, appointed by the chair of the Council of Florida Medical School Deans.

2. Four members appointed by the Governor, one of whom is a representative of the Florida Medical Association or the Florida Osteopathic Medical Association who has supervised or is currently supervising residents, one of whom is a member of the Florida Hospital Association, one of whom is a member of the Safety Net Hospital Alliance, and one of whom is a physician licensed under chapter 458 or chapter 459 practicing at a qualifying institution.

3. Two members appointed by the Secretary of Health Care Administration, one of whom represents a statutory teaching hospital as defined in s. 408.07(46) and one of whom is a physician who has supervised or is currently supervising

residents.

4. Two members appointed by the State Surgeon General, one of whom must represent a teaching hospital as defined in s. 408.07 and one of whom is a physician who has supervised or is currently supervising residents or interns.

5. Two members, one appointed by the President of the Senate and one appointed by the Speaker of the House of the Representatives.

(b)1. The members of the committee appointed under subparagraph (a)1. shall serve 4-year terms. When such members' terms expire, the chair of the Council of Florida Medical School Deans shall appoint new members as detailed in paragraph (a)1. from different medical schools on a rotating basis and may not reappoint a dean from a medical school that has been represented on the committee until all medical schools in the state have had an opportunity to be represented on the committee.

2. The members of the committee appointed under subparagraphs (a)2., 3., and 4. shall serve 4-year terms, with the initial term being 3 years for members appointed under subparagraph (a)4. and 2 years for members appointed under subparagraph (a)3. The committee shall elect a chair to serve for a 1-year term.

(c) Members shall serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

(d) The committee shall convene its first meeting by July 1, 2024, and shall meet as often as necessary to conduct its business, but at least twice annually, at the call of the chair. The committee may conduct its meetings though teleconference or other electronic means. A majority of the members of the committee constitutes a quorum, and a meeting may not be held with less than a quorum present. The affirmative vote of a majority of the members of the committee present is necessary for any official action by the committee.

(e) Beginning on July 1, 2025, the committee shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an annual report that must, at a minimum, detail all of the following:

1. The role of residents and medical faculty in the provision of health care.

2. The relationship of graduate medical education to the state's physician workforce.

3. The typical workload for residents and the role such workload plays in retaining physicians in the long-term workforce.

4. The costs of training medical residents for hospitals and qualifying institutions.

5. The availability and adequacy of all sources of revenue available to support graduate medical education.

6. The use of state funds, including, but not limited to,

intergovernmental transfers, for graduate medical education for each hospital or qualifying institution receiving such funds.

(f) The agency shall provide reasonable and necessary support staff and materials to assist the committee in the performance of its duties. The agency shall also provide the information obtained pursuant to subsection (8) to the committee and assist the committee, as requested, in obtaining any other information deemed necessary by the committee to produce its report.

Section 32. Section 409.91256, Florida Statutes, is created to read:

409.91256 Training, Education, and Clinicals in Health (TEACH) Funding Program.—

(1) PURPOSE AND INTENT.—The Training, Education, and Clinicals in Health (TEACH) Funding Program is created to provide a high-quality educational experience while supporting participating qualified health centers, community mental health centers, rural health clinics, and certified community behavioral health clinics by offsetting administrative costs and loss of revenue associated with training residents and students to become licensed health care practitioners. Further, it is the intent of the Legislature to use the program to support the state Medicaid program and underserved populations by expanding the available health care workforce.

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

(a) "Agency" means the Agency for Health Care Administration.

(b) "Preceptor" means a Florida-licensed health care practitioner who directs, teaches, supervises, and evaluates the learning experience of a resident or student during a clinical rotation.

(c) "Primary care specialty" means general internal medicine, family medicine, obstetrics and gynecology, pediatrics, psychiatry, geriatric medicine, or any other specialty the agency identifies as primary care.

(d) "Qualified facility" means a federally qualified health center, a community mental health center, rural health clinic, or a certified community behavioral health clinic.

(3) APPLICATION FOR REIMBURSEMENT; AGREEMENTS; PARTICIPATION REQUIREMENTS.—The agency shall develop an application process for qualified facilities to apply for funds to offset the administrative costs and loss of revenue associated with establishing, maintaining, or expanding a clinical training program. Upon approving an application, the agency shall enter into an agreement with the qualified facility which, at minimum, must require each qualified facility to do all of the following:

(a) Agree to provide appropriate supervision or precepting for one or more of the following categories of residents or students:

1. Allopathic or osteopathic residents pursuing a primary care specialty.

2. Advanced practice registered nursing students pursuing a primary care specialty.

3. Nursing students.

4. Allopathic or osteopathic medical students.

5. Dental students.

6. Physician assistant students.

7. Behavioral health students, including students studying psychology, clinical social work, marriage and family therapy, or mental health counseling.

(b) Meet and maintain all requirements to operate an accredited residency program if the qualified facility operates a residency program.

(c) Obtain and maintain accreditation from an accreditation body approved by the agency if the qualified facility provides clinical rotations.

(d) Ensure that clinical preceptors meet agency standards for precepting students, including the completion of any training required by the agency.

(e) Submit to the agency quarterly reports by the first day of the second month following the end of a quarter to obtain reimbursement. At a minimum, the report must include all of the following:

1. The type of residency or clinical rotation offered by

the qualified facility, the number of residents or students participating in each type of clinical rotation or residency, and the number of hours worked by each resident or student each month.

2. Evaluations by the residents and student participants of the clinical experience on an evaluation form developed by the agency.

3. An itemized list of administrative costs associated with the operation of the clinical training program, including accreditation costs and other costs relating to the creation, implementation, and maintenance of the program.

4. A calculation of lost revenue associated with operating the clinical training program.

(4) TRAINING.—The agency, in consultation with the Department of Health, shall develop, or contract for the development of, training for preceptors and make such training available in either a live or electronic format. The agency shall also provide technical support for preceptors.

(5) REIMBURSEMENT.—A qualified facility may be reimbursed under this section only to offset the administrative costs or lost revenue associated with training students, allopathic residents, or osteopathic residents who are enrolled in an accredited educational or residency program based in the state.

(a) Subject to an appropriation, the agency may reimburse a qualified facility based on the number of clinical training

hours reported under subparagraph (3)(e)1. The allowed reimbursement per student is as follows:

1. A medical resident at a rate of $50 per hour.

2. A first-year medical student at a rate of $27 per hour.

3. A second-year medical student at a rate of $27 per hour.

4. A third-year medical student at a rate of $29 per hour.

5. A fourth-year medical student at a rate of $29 per hour.

6. A dental student at a rate of $22 per hour.

7. An advanced practice registered nursing student at a rate of $22 per hour.

8. A physician assistant student at a rate of $22 per hour.

9. A behavioral health student at a rate of $15 per hour.

(b) A qualified facility may not be reimbursed more than $75,000 per fiscal year; however, if it operates a residency program, it may be reimbursed up to $100,000 each fiscal year.

(6) DATA.—A qualified facility that receives payment under the program shall furnish information requested by the agency for the purpose of the agency's duties under subsections (7) and (8).

(7) REPORTS.—By December 1, 2025, and each December 1 thereafter, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of

Representatives a report detailing the effects of the program for the prior fiscal year, including, but not limited to, all of the following:

(a) The number of students trained in the program, by school, area of study, and clinical hours earned.

(b) The number of students trained and the amount of program funds received by each participating qualified facility.

(c) The number of program participants found to be employed by a qualified facility or in a federally designated health professional shortage area upon completion of such participants' education and training.

(d) Any other data the agency deems useful for determining the effectiveness of the program.

(8) EVALUATION.—The agency shall contract with an independent third party to develop and conduct a design study to evaluate the impact of the TEACH funding program, including, but not limited to, the program's effectiveness in both of the following areas:

(a) Enabling qualified facilities to provide clinical rotations and residency opportunities to students and medical school graduates, as applicable.

(b) Enabling the recruitment and retention of health care professionals in geographic and practice areas experiencing shortages.

The agency shall begin collecting data for the study by January 1, 2025, and shall submit the results of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2030.

(9) RULES.—The agency may adopt rules to implement this section.

(10) FEDERAL FUNDING.—The agency shall seek federal approval to use Title XIX matching funds for the program.

(11) REPEAL.—This section is repealed on July 1, 2034.

Section 33. Paragraph (e) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

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

(e) *Encounter data.*—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in

accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

3. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

4. The agency shall annually produce a report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees." The report must include, but need not be limited to, an analysis of the potentially preventable hospital emergency department visits, hospital admissions, and hospital readmissions that occurred during the previous state

fiscal year which may have been prevented with better access to primary care, improved medication management, or better coordination of care, reported by age, eligibility group, managed care plan, and region, including conditions contributing to each potentially preventable event or category of potentially preventable events. The agency may include any other data or analysis parameters to augment the report that it deems pertinent to the analysis. The report must demonstrate trends using applicable historical data. The agency shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The agency may contract with a third-party vendor to produce the report required under this subparagraph.

Section 34. Subsection (4) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(a) Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider.

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an appointment with the primary care provider. If possible, the appointment should be made within 30 days after enrollment in the plan. If an appointment is not made within such 30-day period, the plan must continue assisting the enrollee to schedule an initial appointment.

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

(f) Coordinate with a hospital that contacts the plan under the requirements of s. 395.1055(1)(j) for the purpose of establishing the appropriate delivery of primary care services for the plan's members who present at the hospital's emergency department for nonemergent care or emergency care that could potentially have been avoided through the regular provision of primary care. The plan shall coordinate with such member and the member's primary care provider for such purpose.

Section 35. The Agency for Health Care Administration shall seek federal approval necessary to implement an acute

hospital care at home program in the state Medicaid program which is substantially consistent with the parameters specified in 42 U.S.C. s. 1395cc-7(a)(2)-(3).

Section 36. Section 456.0145, Florida Statutes, is created to read:

456.0145 Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.—

(1) SHORT TITLE.—This section may be cited as the "Mobile Opportunity by Interstate Licensure Endorsement Act" or the "MOBILE Act."

(2) LICENSURE BY ENDORSEMENT.—

(a) An applicable board, or the department if there is no board, shall issue a license to practice in this state to an applicant who:

1. Submits a complete application.

2. Holds an active, unencumbered license issued by another state, the District of Columbia, or a possession or territory of the United States in a profession with a similar scope of practice, as determined by the board or department, as applicable. "Scope of practice" means the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license issued in this state.

3. Has obtained a passing score on a national licensure examination, or national certification, as applicable, for which

profession the applicant is seeking licensure in this state, or meets the requirements of paragraph (b).

4. Has actively practiced the profession for which the applicant is applying for at least 2 of the 4 years preceding the date of submission of the application.

5. Attests that he or she is not, at the time of submission of the application, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reasons related to the practice of the profession for which he or she is applying.

6. Has not had disciplinary action taken against him or her in the 5 years preceding the date of submission of the application

7. Meets the financial responsibility requirements of s. 456.048 or the applicable practice act, if required for the profession for which the applicant is seeking licensure.

8. Submits a set of fingerprints for a background screening pursuant to s. 456.0135, if required for the profession for which he or she is applying.

The department shall verify information submitted by the applicant under this subsection using the National Practitioner Data Bank.

(b) An applicant for a profession that does not require a

national examination or national certification is eligible for licensure if an applicable board or the department determines that the jurisdiction in which the applicant currently holds an active, unencumbered license meets established minimum education requirements and, if applicable, examination, work experience, and clinical supervision requirements that are substantially similar to the requirements for licensure in that profession in this state.

(c) An applicant is ineligible for a license pursuant to this section if he or she:

1. Has a complaint, allegation, or investigation pending before a licensing entity in another state, the District of Columbia, or a possession or territory of the United States;

2. Has been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

3. Has had a health care provider license revoked or suspended in another state of the United States, the District of Columbia, or a United States territory or has voluntarily surrendered any such license; or

4. Has been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his or her name removed from the data bank.

(d) The board, or the department if there is no board, may revoke a license upon finding that the applicant provided false

or misleading material information or intentionally omitted material information in an application for licensure.

(e) The board, or the department if there is no board, shall issue a license within 7 days after receipt of all required documentation for an application.

(f) The board, or the department if there is no board, shall comply with the requirements of s. 456.025.

(3) STATE EXAMINATION.—The board, or the department if there is no board, may require the applicant to successfully complete a jurisprudential examination specific to relevant state laws that regulate the profession, if this chapter or the applicable practice act requires such examination.

(4) ANNUAL REPORT.—By December 31 of each year, the department shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that provides all of the following information for the previous fiscal year:

(a) The number of applications for licensure or certification received under this section, distinguished by profession.

(b) The number of licenses or certifications issued under this section.

(c) The number of applications submitted under this section which were denied and the reason for such denials.

(d) The number of complaints, investigations, or other

disciplinary actions taken against health care practitioners who are licensed or certified under this section.

(5) RULES.—By December 1, 2024, each applicable board, or the department if there is no board, shall adopt rules to implement this section.

Section 37. Subsection (10) of section 456.073, Florida Statutes, is amended to read:

456.073 Disciplinary proceedings.—Disciplinary proceedings for each board shall be within the jurisdiction of the department.

(10)(a) The complaint and all information obtained pursuant to the investigation by the department are confidential and exempt from s. 119.07(1) until 10 days after probable cause has been found to exist by the probable cause panel or by the department, or until the regulated professional or subject of the investigation waives his or her privilege of confidentiality, whichever occurs first.

(b) The department shall report any significant investigation information relating to a nurse holding a multistate license to the coordinated licensure information system pursuant to s. 464.0095; any investigative information relating to an audiologist or a speech-language pathologist holding a compact privilege under the Practice of Audiology and Speech-Language Pathology Interstate Compact to the data system pursuant to s. 468.1335; any significant investigatory

information relating to a psychologist practicing under the Psychology Interjurisdictional Compact to the coordinated licensure information system pursuant to s. 490.0075;~~,~~ and any significant investigatory information relating to a health care practitioner practicing under the Professional Counselors Licensure Compact to the data system pursuant to s. 491.017~~, and any significant investigatory information relating to a psychologist practicing under the Psychology Interjurisdictional Compact to the coordinated licensure information system pursuant to s. 490.0075~~.

(c) Upon completion of the investigation and a recommendation by the department to find probable cause, and pursuant to a written request by the subject or the subject's attorney, the department shall provide the subject an opportunity to inspect the investigative file or, at the subject's expense, forward to the subject a copy of the investigative file. Notwithstanding s. 456.057, the subject may inspect or receive a copy of any expert witness report or patient record connected with the investigation if the subject agrees in writing to maintain the confidentiality of any information received under this subsection until 10 days after probable cause is found and to maintain the confidentiality of patient records pursuant to s. 456.057. The subject may file a written response to the information contained in the investigative file. Such response must be filed within 20 days

of mailing by the department, unless an extension of time has been granted by the department.

(d) This subsection does not prohibit the department from providing the complaint and any information obtained pursuant to the department's investigation ~~such information~~ to any law enforcement agency or to any other regulatory agency.

Section 38. Subsection (5) of section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs.—

(5) A consultant shall enter into a participant contract with an impaired practitioner and shall establish the terms of monitoring and shall include the terms in a participant contract. In establishing the terms of monitoring, the consultant may consider the recommendations of one or more approved evaluators, treatment programs, or treatment providers. A consultant may modify the terms of monitoring if the consultant concludes, through the course of monitoring, that extended, additional, or amended terms of monitoring are required for the protection of the health, safety, and welfare of the public. If the impaired practitioner is a physical therapist or physical therapist assistant practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, a psychologist practicing under the Psychology Interjurisdictional Compact pursuant to s. 490.0075, or a health care practitioner practicing under the Professional Counselors Licensure Compact

pursuant to s. 491.017, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact. If the impaired practitioner is a physical therapist or physical therapist assistant practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112 ~~psychologist practicing under the Psychology Interjurisdictional Compact pursuant to s. 490.0075~~, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact unless authorized by a member state.

Section 39. Section 456.4501, Florida Statutes, is created to read:

456.4501 Interstate Medical Licensure Compact.—The Interstate Medical Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

SECTION 1

PURPOSE

In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of

state medical boards and provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure and does not otherwise change a state's existing medical practice act. The compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the compact.

SECTION 2

DEFINITIONS

As used in this compact, the term:

(1) "Bylaws" means those bylaws established by the Interstate Commission pursuant to Section 11 for its governance, or for directing and controlling its actions and conduct.

(2) "Commissioner" means the voting representative appointed by each member board pursuant to Section 11.

(3) "Convicted" means a finding by a court that an individual is guilty of a criminal offense through adjudication or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

(4) "Expedited license" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.

(5) "Interstate Commission" means the Interstate Medical Licensure Compact Commission created pursuant to Section 11.

(6) "License" means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.

(7) "Medical practice act" means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

(8) "Member board" means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government.

(9) "Member state" means a state that has enacted the Compact.

(10) "Offense" means a felony, high court misdemeanor, or crime of moral turpitude.

(11) "Physician" means any person who:

(a) Is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;

(b) Passed each component of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(c) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(d) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists; however, the specialty certification or a time-unlimited specialty certificate does not have to be maintained once a physician is initially determined to be eligible for expedited licensure through the Compact;

(e) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(f) Has never been convicted, received adjudication,

deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(g) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license;

(h) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and

(i) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

(12) "Practice of medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do any of these acts.

(13) "Rule" means a written statement by the Interstate Commission adopted pursuant to section 12 of the compact which is of general applicability; implements, interprets, or prescribes a policy or provision of the compact, or an organizational, procedural, or practice requirement of the Interstate Commission; and has the force and effect of statutory

law in a member state, if the rule is not inconsistent with the laws of the member state. The term includes the amendment, repeal, or suspension of an existing rule.

(14) "State" means any state, commonwealth, district, or territory of the United States.

(15) "State of principal license" means a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the Compact.

SECTION 3

ELIGIBILITY

(1) A physician must meet the eligibility requirements as provided in subsection (11) of section 2 to receive an expedited license under the terms and provisions of the Compact.

(2) A physician who does not meet the requirements as provided in subsection (11) of section 2 may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the Compact, relating to the issuance of a license to practice medicine in that state.

SECTION 4

DESIGNATION OF STATE OF PRINCIPAL LICENSE

(1) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

(a) The state of primary residence for the physician, or

(b) The state where at least 25 percent of the physician's practice of medicine occurs, or

(c) The location of the physician's employer, or

(d) If no state qualifies under paragraph (a), paragraph (b), or paragraph (c), the state designated as the state of residence for purpose of federal income tax.

(2) A physician may redesignate a member state as the state of principal license at any time, as long as the state meets one of the descriptions under subsection (1).

(3) The Interstate Commission may develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5

APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

(1) A physician seeking licensure through the compact must file an application for an expedited license with the member board of the state selected by the physician as the state of

principal license.

(2) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission.

(a) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the Interstate Commission through rule, are not subject to additional primary source verification if already primary source verified by the state of principal license.

(b) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have a suitability determination in accordance with U.S. 5 C.F.R. s. 731.202.

(c) Appeal on the determination of eligibility must be made to the member state where the application was filed and is subject to the law of that state.

(3) Upon verification in subsection (2), physicians

eligible for an expedited license must complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (1), including the payment of any applicable fees.

(4) After receiving verification of eligibility under subsection (2) and upon an applicant's completion of any registration process, including the payment of any applicable fees, required under subsection (3), a member board shall issue an expedited license to the physician. This license authorizes the physician to practice medicine in the issuing state consistent with the medical practice act and all applicable laws and regulations of the issuing member board and member state.

(5) An expedited license is valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full and unrestricted license within the member state.

(6) An expedited license obtained through the compact must be terminated if a physician fails to maintain a license in the state of principal licensure for a nondisciplinary reason, without redesignation of a new state of principal licensure.

(7) The Interstate Commission may develop rules regarding the application process, including payment of any applicable fees, and the issuance of an expedited license.

SECTION 6

FEES FOR EXPEDIATED LICENSURE

(1) A member state issuing an expediated license authorizing the practice of medicine in that state may impose a fee for a license issued or renewed through the compact.

(2) The Interstate Commission is authorized to develop rules regarding fees for expediated licenses.

SECTION 7

RENEWAL AND CONTINUED PARTICIPATION

(1) A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the physician:

(a) Maintains a full and unrestricted license in a state of principal license;

(b) Has not been convicted or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(c) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license; and

(d) Has not had a controlled substance license or permit

suspended or revoked by a state or the United States Drug Enforcement Administration.

(2) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(3) The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(4) Upon receipt of any renewal fees collected in subsection (3), a member board shall renew the physician's license.

(5) Physician information collected by the Interstate Commission during the renewal process must distributed to all member boards.

(6) The Interstate Commission may develop rules to address renewal of licenses obtained through the Compact.

SECTION 8

COORDINATED INFORMATION SYSTEM

(1) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under Section 5.

(2) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public

action or complaints against a licensed physician who has applied or received an expedited license through the Compact.

(3) Member boards shall report to the Interstate Commission disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(4) Member boards may report to the Interstate Commission any nonpublic complaint, disciplinary, or investigatory information not required by subsection (3) to the Interstate Commission.

(5) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(6) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(g) The Interstate Commission may develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9

JOINT INVESTIGATIONS

(1) Licensure and disciplinary records of physicians are deemed investigative.

(2) In addition to the authority granted to a member board by its respective medical practice act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

(3) A subpoena issued by a member state is enforceable in other member states.

(4) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

(5) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 10

DISCIPLINARY ACTIONS

(1) Any disciplinary action taken by any member board against a physician licensed through the compact is deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the medical practice act or regulations in that state.

(2) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered

or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board must remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the medical practice act of that state.

(3) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

(a) Impose the same or lesser sanctions against the physician so long as such sanctions are consistent with the medical practice act of that state; or

(b) Pursue separate disciplinary action against the physician under its respective medical practice act, regardless of the action taken in other member states.

(4) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, any licenses issued to the physician by any other member boards, for 90 days after entry of the order by the disciplining board, to permit the member boards to investigate the basis for the action under the medical practice act of that

state. A member board may terminate the automatic suspension of the license it issued before the completion of the ninety (90) day suspension period in a manner consistent with the medical practice act of that state.

SECTION 11

INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(1) The member states hereby create the "Interstate Medical Licensure Compact Commission."

(2) The purpose of the Interstate Commission is the administration of the compact, which is a discretionary state function.

(3) The Interstate Commission is a body corporate and joint agency of the member states and has all the responsibilities, powers, and duties set forth in the compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the compact.

(4) The Interstate Commission shall consist of two voting representatives appointed by each member state who shall serve as commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall

appoint one representative from each member board. Each commissioner must be one of the following:

(a) An allopathic or osteopathic physician appointed to a member board;

(b) An executive director, an executive secretary, or a similar executive of a member board; or

(c) A member of the public appointed to a member board.

(5) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting must be a business meeting to address such matters as may properly come before the Commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(6) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or other electronic means.

(7) Each commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of commissioners constitutes a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A commissioner may not delegate a vote to another commissioner. In the absence of its commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who must meet the qualification requirements specified in subsection (4).

(h) The Interstate Commission shall provide public notice of all meetings, and all meetings must be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the Commissioners present that an open meeting would be likely to:

(a) Relate solely to the internal personnel practices and procedures of the Interstate Commission;

(b) Discuss matters specifically exempted from disclosure by federal statute;

(c) Discuss trade secrets or commercial or financial information that is privileged or confidential;

(d) Involve accusing a person of a crime, or formally censuring a person;

(e) Discuss information of a personal nature where disclosure of which would constitute a clearly unwarranted invasion of personal privacy;

(f) Discuss investigative records compiled for law enforcement purposes; or

(g) Specifically relate to the participation in a civil action or other legal proceeding.

(9) The Interstate Commission shall keep minutes that fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including a record of any roll call votes.

(10) The Interstate Commission shall make its information

and official records, to the extent not otherwise designated in the compact or by its rules, available to the public for inspection.

(11) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee has the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the compact, including enforcement and compliance with the compact, its bylaws and rules, and other such duties as necessary.

(12) The Interstate Commission may establish other committees for governance and administration of the compact.

SECTION 12

POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The Interstate Commission has all of the following powers and duties:

(1) Overseeing and maintaining the administration of the compact.

(2) Adopting rules which shall be binding to the extent and in the manner provided for in the compact.

(3) Issuing, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the compact, its bylaws, rules, and actions.

(4) Enforcing compliance with the compact, the rules adopted by the Interstate Commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process.

(5) Establishing and appointing committees, including, but not limited to, an executive committee as required by section 10, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties.

(6) Paying for, or providing for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission.

(7) Establishing and maintaining one or more offices;

(8) Borrowing, accepting, hiring, or contracting for services of personnel.

(9) Purchasing and maintaining insurance and bonds.

(10) Employing an executive director who shall have such powers to employ, select or appoint employees, agents, or consultants, and to determine their qualifications, define their duties, and fix their compensation.

(11) Establishing personnel policies and programs relating to conflicts of interest, rates of compensation, and qualifications of personnel.

(12) Accepting donations and grants of money, equipment, supplies, materials and services, and receiving, using, and disposing of it in a manner consistent with the conflict of interest policies established by the Interstate Commission.

(13) Leasing, purchasing, accepting contributions or donations of, or otherwise to owning, holding, improving, or using, any property, real, personal, or mixed.

(14) Selling, conveying, mortgaging, pledging, leasing, exchanging, abandoning, or otherwise disposing of any property, real, personal, or mixed.

(15) Establishing a budget and making expenditures.

(16) Adopting a seal and bylaws governing the management and operation of the Interstate Commission.

(17) Reporting annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the preceding year. Such reports must also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission.

(18) Coordinating education, training, and public awareness regarding the compact and its implementation and operation;

(19) Maintaining records in accordance with the bylaws.

(20) Seeking and obtaining trademarks, copyrights, and patents.

(21) Performing any other functions necessary or

appropriate to achieve the purposes of the compact.

SECTION 13

FINANCE POWERS

(1) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment, subject to appropriation, must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated upon a formula to be determined by the Interstate Commission, which shall adopt a rule binding upon all member states.

(2) The Interstate Commission may not incur obligations of any kind prior to securing the funds adequate to meet the same.

(3) The Interstate Commission may not pledge the credit of any of the member states, except by, and with the authority of, the member state.

(4) The Interstate Commission is subject to an annual financial audit conducted by a certified or licensed public accountant and the report of the audit must be included in the annual report of the Interstate Commission.

SECTION 14

ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

(1) The Interstate Commission shall, by a majority of commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact within 12 months after the first Interstate Commission meeting.

(2) The Interstate Commission shall elect or appoint annually from among its commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(3) Officers selected pursuant to subsection (2) shall serve without remuneration from the Interstate Commission.

(4) The officers and employees of the Interstate Commission are immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties, or responsibilities; provided that such person is not protected from suit or

liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(a) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The Interstate Commission is considered to be an instrumentality of the states for the purposes of any such action. This subsection does not protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(b) The Interstate Commission shall defend the executive director and its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, shall defend such persons in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged

act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(c) To the extent not covered by the state involved, the member state, or the Interstate Commission, the representatives or employees of the Interstate Commission must be held harmless in the amount of a settlement or judgment, including attorney fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

SECTION 15

RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(1) The Interstate Commission shall adopt reasonable rules in order to effectively and efficiently achieve the purposes of the compact. However, in the event the Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the compact, or the powers granted hereunder, then such an action by the Interstate Commission is

invalid and has no force or effect.

(2) Rules deemed appropriate for the operations of the Interstate Commission must be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, and subsequent amendments thereto.

(3) Not later than 30 days after a rule is adopted, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided that the filing of such a petition does not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court must give deference to the actions of the Interstate Commission consistent with applicable law and does not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16

OVERSIGHT OF INTERSTATE COMPACT

(1) The executive, legislative, and judicial branches of state government in each member state shall enforce the Compact and shall take all actions necessary and appropriate to

effectuate the compact's purposes and intent. The compact and the rules adopted hereunder has standing as statutory law but may not override existing state authority to regulate the practice of medicine.

(2) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(3) The Interstate Commission is entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the compact, or adopted rules, as applicable.

SECTION 17

ENFORCEMENT OF INTERSTATE COMPACT

(1) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the Compact.

(2) The Interstate Commission may, by majority vote of the commissioners, initiate legal action in the United States

District Court for the District of Columbia, or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the compact, and its adopted rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party must be awarded all costs of such litigation including reasonable attorney fees.

(3) The remedies herein are not the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or the regulation of a profession.

SECTION 18

DEFAULT PROCEDURES

(1) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the compact, or the rules and bylaws of the Interstate Commission adopted under the compact.

(2) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact, or the bylaws or adopted

rules, the Interstate Commission shall:

(a) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state must cure its default; and

(b) Provide remedial training and specific technical assistance regarding the default.

(3) If the defaulting state fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the commissioners and all rights, privileges, and benefits conferred by the compact shall terminate on the effective date of the termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

(4) Termination of membership in the compact must be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate must be given by the Interstate Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

(5) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the

withdrawal of a member state.

(6) The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination, including obligations, the performance of which extends beyond the effective date of termination.

(7) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(8) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party must be awarded all costs of such litigation including reasonable attorney's fees.

SECTION 19

DISPUTE RESOLUTION

(1) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes that are subject to the compact and that may arise among member states or member boards.

(2) The Interstate Commission shall adopt rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 20

MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

(1) Any state is eligible to become a member state of the compact.

(2) The Compact shall become effective and binding upon legislative enactment of the compact into law by no less than 7 states. Thereafter, it becomes effective and binding on a state upon enactment of the compact into law by that state.

(3) The governors of nonmember states, or their designees, must be invited to participate in the activities of the Interstate Commission on a nonvoting basis before adoption of the compact by all states.

(4) The Interstate Commission may propose amendments to the compact for enactment by the member states. An amendment does not become effective and binding upon the Interstate Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 21

WITHDRAWAL

(1) Once effective, the compact shall continue in force and remain binding upon each and every member state. However, a member state may withdraw from the compact by specifically repealing the statute which enacted the Compact into law.

(2) Withdrawal from the compact must be made by the enactment of a statute repealing the same, but the withdrawal may not take effect until one year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(3) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the compact in the withdrawing state.

(4) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw within 60 days after the receipt of notice provided under subsection (3).

(5) The withdrawing state is responsible for all dues, obligations, and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(6) Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the compact or

upon such later date as determined by the Interstate Commission.

(7) The Interstate Commission may develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 22

DISSOLUTION

(1) The compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the compact to one member state.

(2) Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission must be concluded, and surplus funds of the Interstate Commission must be distributed in accordance with the bylaws.

SECTION 23

SEVERABILITY AND CONSTRUCTION

(1) The provisions of the compact are be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact remain

enforceable.

(2) The provisions of the compact must be liberally construed to effectuate its purposes.

(3) The compact does not prohibit the applicability of other interstate compacts to which the states are members.

SECTION 24

BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) Nothing herein prevents the enforcement of any other law of a member state which is not inconsistent with the Compact.

(2) All laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

(3) All lawful actions of the Interstate Commission, including all rules and bylaws adopted by the commission, are binding upon the member states.

(4) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(5) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, such provision is ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 40. Section 456.4502, Florida Statutes, is created

to read:

456.4502 Interstate Medical Licensure Compact; disciplinary proceedings.—A physician licensed pursuant to chapter 458, chapter 459, or s. 456.4501 whose license is suspended or revoked by this state pursuant to the Interstate Medical Licensure Compact as a result of disciplinary action taken against the physician's license in another state must be granted a formal hearing before an administrative law judge from the Division of Administrative Hearings held pursuant to chapter 120 if there are any disputed issues of material fact. In such proceedings:

(1) Notwithstanding s. 120.569(2), the department shall notify the division within 45 days after receipt of a petition or request for a formal hearing.

(2) The determination of whether the physician has violated the laws and rules regulating the practice of medicine or osteopathic medicine, as applicable, including a determination of the reasonable standard of care, is a conclusion of law that is to be determined by appropriate board, and is not a finding of fact to be determined by an administrative law judge.

(3) The administrative law judge shall issue a recommended order pursuant to chapter 120.

(4) The Board of Medicine or the Board of Osteopathic Medicine, as applicable, shall determine and issue the final

order in each disciplinary case. Such order shall constitute final agency action.

(5) Any consent order or agreed-upon settlement is subject to the approval of the department.

(6) The department shall have standing to seek judicial review of any final order of the board, pursuant to s. 120.68.

Section 41. Section 456.4504, Florida Statutes, is created to read:

456.4504 Interstate Medical Licensure Compact Rules.—The department may adopt rules to implement the Interstate Medical Licensure Compact.

Section 42. The provisions of the Interstate Medical Licensure Compact do not authorize the Department of Health, the Board of Medicine, or the Board of Osteopathic Medicine to collect a fee for expedited licensure, but rather state that such fees are allowable under the compact. The Department of Health, the Board of Medicine, and the Board of Osteopathic Medicine must comply with the requirements of s. 456.025.

Section 43. Paragraph (c) of subsection (2) of section 457.105, Florida Statutes, is amended to read:

457.105 Licensure qualifications and fees.—

(2) A person may become licensed to practice acupuncture if the person applies to the department and:

(c) Has successfully completed a board-approved national certification process, meets the requirements for licensure by

endorsement in s. 456.0145 ~~is actively licensed in a state that has examination requirements that are substantially equivalent to or more stringent than those of this state~~, or passes an examination administered by the department, which examination tests the applicant's competency and knowledge of the practice of acupuncture and oriental medicine. At the request of any applicant, oriental nomenclature for the points shall be used in the examination. The examination shall include a practical examination of the knowledge and skills required to practice modern and traditional acupuncture and oriental medicine, covering diagnostic and treatment techniques and procedures; and

Section 44. Subsections (3) through (8) of section 458.311, Florida Statutes, are renumbered as subsections (4) through (9), respectively, paragraph (f) of subsection (1) and present subsections (3) and (5) are amended, and a new subsection (3) is added to that section, to read:

458.311 Licensure by examination; requirements; fees.—

(1) Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply to the department on forms furnished by the department. The department shall license each applicant who the board certifies:

(f) Meets one of the following medical education and postgraduate training requirements:

1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting

agency recognized by the United States Office of Education or is a graduate of an allopathic medical school or allopathic college within a territorial jurisdiction of the United States recognized by the accrediting agency of the governmental body of that jurisdiction;

b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

2.a. Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to s. 458.314 as having met the standards required to accredit medical schools in the United States or reasonably comparable standards;

b. If the language of instruction of the foreign medical school is other than English, has demonstrated competency in English through presentation of the Educational Commission for Foreign Medical Graduates English proficiency certificate or by a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

3.a. Is a graduate of an allopathic foreign medical school

which has not been certified pursuant to s. 458.314 and has not been excluded from consideration under s. 458.314(8);

b. Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination utilized by that commission; and

c. Has completed an approved residency of at least 1 year; however, after October 1, 1992, the applicant shall have completed an approved residency or fellowship of at least 2 years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties.

(3) Notwithstanding sub-subparagraphs (1)(f)2.c. and 3.c., a graduate of a foreign medical school that has not been excluded from consideration under s. 458.314(8) is not required to complete an approved residency if he or she meets all of the following criteria:

(a) Has an active, unencumbered license to practice medicine in a foreign country.

(b) Has actively practiced medicine in the 4-year period preceding the date of the submission of a licensure application.

(c) Has completed a residency or substantially similar postgraduate medical training in a country recognized by his or her licensing jurisdiction.

(d) Has an offer for full-time employment as a physician from a health care provider that operates in this state.

A physician licensed after meeting the requirements of this subsection must maintain his or her employment with the original employer under paragraph (d) or with another health care provider that operates in this state, at a location within this state, for at least 2 consecutive years after licensure, in accordance with rules adopted by the board. Such physician must notify the board within 5 business days after any change of employer.

(4) ~~(3)~~ Notwithstanding the provisions of subparagraph (1)(f)3., a graduate of a foreign medical school that has not been excluded from consideration under s. 458.314(8) need not present the certificate issued by the Educational Commission for Foreign Medical Graduates or pass the examination utilized by that commission if the graduate:

(a) Has received a bachelor's degree from an accredited United States college or university.

(b) Has studied at a medical school which is recognized by the World Health Organization.

(c) Has completed all of the formal requirements of the foreign medical school, except the internship or social service requirements, and has passed part I of the National Board of Medical Examiners examination or the Educational Commission for

Foreign Medical Graduates examination equivalent.

(d) Has completed an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion has passed part II of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

(6) ~~(5)~~ The board may not certify to the department for licensure any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter until such investigation is completed. Upon completion of the investigation, ~~the provisions of~~ s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, ~~then~~ the board may enter an order imposing one or more of the terms set forth in subsection (9) ~~(8)~~.

Section 45. Section 458.3124, Florida Statutes, is repealed.

Section 46. Section 458.313, Florida Statutes, is amended

to read:

458.313 Licensure by endorsement; requirements; fees.—

~~(1)~~ The department shall issue a license by endorsement to any applicant who, upon applying to the department on forms furnished by the department and remitting a fee set by the board not to exceed $500, the board certifies has met the requirements for licensure by endorsement in s. 456.0145.~~:~~

~~(a) Has met the qualifications for licensure in s. 458.311(1)(b)-(g) or in s. 458.311(1)(b)-(e) and (g) and (3);~~

~~(b) Prior to January 1, 2000, has obtained a passing score, as established by rule of the board, on the licensure examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), on the United States Medical Licensing Examination (USMLE), or on the examination of the National Board of Medical Examiners, or on a combination thereof, and on or after January 1, 2000, has obtained a passing score on the United States Medical Licensing Examination (USMLE); and~~

~~(c) Has submitted evidence of the active licensed practice of medicine in another jurisdiction, for at least 2 of the immediately preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure. For~~

~~purposes of this paragraph, "active licensed practice of medicine" means that practice of medicine by physicians, including those employed by any governmental entity in community or public health, as defined by this chapter, medical directors under s. 641.495(11) who are practicing medicine, and those on the active teaching faculty of an accredited medical school.~~

~~(2) The board may require an applicant for licensure by endorsement to take and pass the appropriate licensure examination prior to certifying the applicant as eligible for licensure.~~

~~(3) The department and the board shall ensure that applicants for licensure by endorsement meet applicable criteria in this chapter through an investigative process. When the investigative process is not completed within the time set out in s. 120.60(1) and the department or board has reason to believe that the applicant does not meet the criteria, the State Surgeon General or the State Surgeon General's designee may issue a 90-day licensure delay which shall be in writing and sufficient to notify the applicant of the reason for the delay. The provisions of this subsection shall control over any conflicting provisions of s. 120.60(1).~~

~~(4) The board may promulgate rules and regulations, to be applied on a uniform and consistent basis, which may be necessary to carry out the provisions of this section.~~

~~(5) Upon certification by the board, the department shall~~

~~impose conditions, limitations, or restrictions on a license by endorsement if the applicant is on probation in another jurisdiction for an act which would constitute a violation of this chapter.~~

~~(6) The department shall not issue a license by endorsement to any applicant who is under investigation in any jurisdiction for an act or offense which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, the board may enter an order imposing one or more of the terms set forth in subsection (7).~~

~~(7) When the board determines that any applicant for licensure by endorsement has failed to meet, to the board's satisfaction, each of the appropriate requirements set forth in this section, it may enter an order requiring one or more of the following terms:~~

~~(a) Refusal to certify to the department an application for licensure, certification, or registration;~~

~~(b) Certification to the department of an application for~~

~~licensure, certification, or registration with restrictions on the scope of practice of the licensee; or~~

~~(c) Certification to the department of an application for licensure, certification, or registration with placement of the physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another physician.~~

Section 47. Subsection (8) of section 458.314, Florida Statutes, is amended to read:

458.314 Certification of foreign educational institutions.—

(8) If a foreign medical school does not seek certification under this section, the board may, at its discretion, exclude the foreign medical school from consideration as an institution that provides medical education that is reasonably comparable to that of similar accredited institutions in the United States and that adequately prepares its students for the practice of medicine in this state. However, a license or medical faculty certificate issued to a physician under this chapter before July 1, 2024, is not affected by this subsection ~~Each institution which has been surveyed before October 1, 1986, by the Commission to Evaluate Foreign Medical Schools or the Commission on Foreign Medical~~

~~Education of the Federation of State Medical Boards, Inc., and whose survey and supporting documentation demonstrates that it provides an educational program, including curriculum, reasonably comparable to that of similar accredited institutions in the United States shall be considered fully certified, for purposes of chapter 86-245, Laws of Florida~~.

Section 48. Subsections (5) and (6) of section 458.3145, Florida Statutes, are renumbered as subsections (4) and (5), respectively, and subsection (1) and present subsection (4) of that section are amended, to read:

458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without examination to an individual who meets all of the following criteria:

(a) Is a graduate of an accredited medical school or its equivalent, or is a graduate of a foreign medical school listed with the World Health Organization which has not been excluded from consideration under s. 458.314(8).~~;~~

(b) Holds a valid, current license to practice medicine in another jurisdiction.~~;~~

(c) Has completed the application form and remitted a nonrefundable application fee not to exceed $500.~~;~~

(d) Has completed an approved residency or fellowship of at least 1 year or has received training that ~~which~~ has been determined by the board to be equivalent to the 1-year residency

requirement.~~;~~

(e) Is at least 21 years of age.~~;~~

(f) Is of good moral character.~~;~~

(g) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331.~~;~~

(h) For any applicant who has graduated from medical school after October 1, 1992, has completed, before entering medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which must include, at a minimum, courses in such fields as anatomy, biology, and chemistry.~~; and~~

(i) Has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at any of the following institutions:

1. The University of Florida.~~;~~

2. The University of Miami.~~;~~

3. The University of South Florida.~~;~~

4. The Florida State University.~~;~~

5. The Florida International University.~~;~~

6. The University of Central Florida.~~;~~

7. The Mayo Clinic College of Medicine and Science in Jacksonville, Florida.~~;~~

8. The Florida Atlantic University.~~;~~

9. The Johns Hopkins All Children's Hospital in St.

Petersburg, Florida.~~;~~

10. Nova Southeastern University.~~; or~~

11. Lake Erie College of Osteopathic Medicine.

~~(4) In any year, the maximum number of extended medical faculty certificateholders as provided in subsection (2) may not exceed 30 persons at each institution named in subparagraphs (1)(i)1.-6., 8., and 9. and at the facility named in s. 1004.43 and may not exceed 10 persons at the institution named in subparagraph (1)(i)7.~~

Section 49. Section 458.315, Florida Statutes, is amended to read:

458.315 Temporary certificate for practice in areas of critical need.—

(1) A physician or physician assistant who is licensed to practice in any jurisdiction of the United States and~~,~~ whose license is currently valid~~, and who pays an application fee of $300~~ may be issued a temporary certificate for practice in areas of critical need. A physician seeking such certificate must pay an application fee of $300.

(2) A temporary certificate may be issued under this section to a physician or physician assistant who will:

(a) ~~Will~~ Practice in an area of critical need;

(b) ~~Will~~ Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s.

330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care services to meet the needs of underserved populations in this state; or

(c) ~~Will~~ Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

(3) The board ~~of Medicine~~ may issue a ~~this~~ temporary certificate under this section subject to ~~with~~ the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied, as applicable.

(b) The board may administer an abbreviated oral

examination to determine the physician's or physician assistant's competency, but a written regular examination is not required. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant has not actively practiced during the 3-year period immediately preceding the application ~~prior 3 years~~ and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate having reasonable restrictions that may include, but are not limited to, a requirement for the applicant to practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid

only so long as the State Surgeon General determines that the reason for which it was issued remains a critical need to the state. The board ~~of Medicine~~ shall review each temporary certificateholder at least ~~not less than~~ annually to ascertain that the certificateholder is complying with the minimum requirements of the Medical Practice Act and its adopted rules, as applicable to the certificateholder ~~are being complied with~~. If it is determined that the certificateholder is not meeting such minimum requirements ~~are not being met~~, the board must ~~shall~~ revoke such certificate or ~~shall~~ impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any physician or physician assistant who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this chapter until such time as the investigation is complete, at which time ~~the provisions of~~ s. 458.331 applies ~~apply~~.

(4) The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or

institution stating that the physician or physician assistant will not receive any compensation for any health care services provided by the applicant ~~service involving the practice of medicine~~.

Section 50. Section 458.317, Florida Statutes, is amended to read:

458.317 Limited licenses.—

(1) PHYSICIANS LICENSED IN UNITED STATES JURISDICTIONS.—

(a) Any person desiring to obtain a limited license under this subsection shall submit to the board an application and fee not to exceed $300 and demonstrate that he or she has been licensed to practice medicine in any jurisdiction in the United States for at least 10 years and intends to practice only pursuant to the restrictions of a limited license granted pursuant to this subsection ~~section~~. However, a physician who is not fully retired in all jurisdictions may use a limited license only for noncompensated practice. If the person applying for a limited license submits a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license shall pay such fees if the person receives compensation for the practice of medicine.

(b) If it has been more than 3 years since active practice

was conducted by the applicant, the full-time director of the county health department or a licensed physician, approved by the board, must ~~shall~~ supervise the applicant for a period of 6 months after he or she is granted a limited license under this subsection ~~for practice~~, unless the board determines that a shorter period of supervision will be sufficient to ensure that the applicant is qualified for licensure. Procedures for such supervision must ~~shall~~ be established by the board.

(c) The recipient of a limited license under this subsection may practice only in the employ of public agencies or institutions or nonprofit agencies or institutions meeting the requirements of s. 501(c)(3) of the Internal Revenue Code, which agencies or institutions are located in the areas of critical medical need as determined by the board. Determination of medically underserved areas shall be made by the board after consultation with the department ~~of Health~~ and statewide medical organizations; however, such determination shall include, but not be limited to, health professional shortage areas designated by the United States Department of Health and Human Services. A recipient of a limited license under this subsection may use the license to work for any approved employer in any area of critical need approved by the board.

(d) The recipient of a limited license shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all

approved institutions where practice privileges have been denied.

(e) This subsection does not limit ~~Nothing herein limits in any way~~ any policy by the board, otherwise authorized by law, to grant licenses to physicians duly licensed in other states under conditions less restrictive than the requirements of this subsection ~~section~~. Notwithstanding the other provisions of this subsection ~~section~~, the board may refuse to authorize a physician otherwise qualified to practice in the employ of any agency or institution otherwise qualified if the agency or institution has caused or permitted violations of the provisions of this chapter which it knew or should have known were occurring.

(f) ~~(2)~~ The board shall notify the director of the full-time local county health department of any county in which a licensee intends to practice under ~~the provisions of~~ this subsection ~~act~~. The director of the full-time county health department shall assist in the supervision of any licensee within the county and shall notify the board ~~which issued the licensee his or her license~~ if he or she becomes aware of any actions by the licensee which would be grounds for revocation of the limited license. The board shall establish procedures for such supervision.

(g) ~~(3)~~ The board shall review the practice of each licensee biennially to verify compliance with the restrictions

prescribed in this subsection ~~section~~ and other applicable provisions of this chapter.

(h) ~~(4)~~ Any person holding an active license to practice medicine in this ~~the~~ state may convert that license to a limited license under this subsection for the purpose of providing volunteer, uncompensated care for low-income Floridians. The applicant must submit a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine. The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for such applicant.

(2) GRADUATE ASSISTANT PHYSICIANS.— A graduate assistant physician is a medical school graduate who meets the requirements of this subsection and has obtained a limited license from the board for the purpose of practicing temporarily under the direct supervision of a physician who has a full, active, and unencumbered license issued under this chapter, pending the graduate's entrance into a residency under the National Resident Match Program.

(a) Any person desiring to obtain a limited license as a graduate assistant physician must submit to the board an application and demonstrate that he or she meets all of the following criteria:

1. Is a graduate of an allopathic medical school or

allopathic college approved by an accrediting agency recognized by the United States Department of Education.

2. Has successfully passed all parts of the United States Medical Licensing Examination.

3. Has not received and accepted a residency match from the National Resident Matching Program within the first year following graduation from medical school.

(b) The board shall issue a graduate assistant physician limited license for a duration of 2 years to an applicant who meets the requirements of paragraph (a) and all of the following criteria:

1. Is at least 21 years of age.

2. Is of good moral character.

3. Submits documentation that the applicant has agreed to enter into a written protocol drafted by a physician with a full, active, and unencumbered license issued under this chapter upon the board's issuance of a limited license to the applicant and submits a copy of the protocol. The board shall establish by rule specific provisions that must be included in a physician-drafted protocol.

4. Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331.

5. Has submitted to the department a set of fingerprints on a form and under procedures specified by the department.

6. The board may not certify to the department for limited licensure under this subsection any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter or chapter 456 until such investigation is completed. Upon completion of the investigation, s. 458.331 applies. Furthermore, the department may not issue a limited license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 458.331. If the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 458.331, the board may enter an order imposing one of the following terms:

a. Refusal to certify to the department an application for a graduate assistant physician limited license; or

b. Certification to the department of an application for a graduate assistant physician limited license with restrictions on the scope of practice of the licensee.

(c) A graduate assistant physician limited licensee may apply for a one-time renewal of his or her limited license by submitting a board-approved application, documentation of actual practice under the required protocol during the initial limited licensure period, and documentation of applications he or she has submitted for accredited graduate medical education training programs. The one-time renewal terminates after 1 year.

(d) A limited licensed graduate assistant physician may provide health care services only under the direct supervision of a physician with a full, active, and unencumbered license issued under this chapter.

(e) A physician must be approved by the board to supervise a limited licensed graduate assistant physician.

(f) A physician may supervise no more than two graduate assistant physicians with limited licenses.

(g) Supervision of limited licensed graduate assistant physicians requires the physical presence of the supervising physician at the location where the services are rendered.

(h) A physician-drafted protocol must specify the duties and responsibilities of the limited licensed graduate assistant physician according to criteria adopted by board rule.

(i) Each protocol that applies to a limited licensed graduate assistant physician and his or her supervising physician must ensure that:

1. There is a process for the evaluation of the limited licensed graduate assistant physicians' performance; and

2. The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the graduate assistant physician's level of competency.

(j) A limited licensed graduate assistant physician's prescriptive authority is governed by the physician-drafted

protocol and criteria adopted by the board and may not exceed that of his or her supervising physician. Any prescriptions and orders issued by the graduate assistant physician must identify both the graduate assistant physician and the supervising physician.

(k) A physician who supervises a graduate assistant physician is liable for any acts or omissions of the graduate assistant physician acting under the physician's supervision and control. Third-party payors may reimburse employers of graduate assistant physicians for covered services rendered by graduate assistant physicians.

(3) RULES.—The board may adopt rules to implement this section.

Section 51. Section 459.0075, Florida Statutes, is amended to read:

459.0075 Limited licenses.—

(1) PHYSICIANS LICENSED IN UNITED STATES JURISDICTIONS.—

(a) Any person desiring to obtain a limited license under this subsection must ~~shall~~:

1.~~(a)~~ Submit to the board a licensure application and fee required by this chapter. However, an osteopathic physician who is not fully retired in all jurisdictions may use a limited license only for noncompensated practice. If the person applying for a limited license submits a statement from the employing agency or institution stating that she or he will not receive

monetary compensation for any service involving the practice of osteopathic medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license must ~~shall~~ pay such fees if the person receives compensation for the practice of osteopathic medicine.

2.~~(b)~~ Submit proof that such osteopathic physician has been licensed to practice osteopathic medicine in any jurisdiction in the United States in good standing and pursuant to law for at least 10 years.

3.~~(c)~~ Complete an amount of continuing education established by the board.

(b)~~(2)~~ If it has been more than 3 years since active practice was conducted by the applicant, the full-time director of the local county health department must ~~shall~~ supervise the applicant for a period of 6 months after the applicant is granted a limited license under this subsection ~~to practice~~, unless the board determines that a shorter period of supervision will be sufficient to ensure that the applicant is qualified for licensure under this subsection ~~pursuant to this section~~. Procedures for such supervision must ~~shall~~ be established by the board.

(c)~~(3)~~ The recipient of a limited license under this subsection may practice only in the employ of public agencies or institutions or nonprofit agencies or institutions meeting the

requirements of s. 501(c)(3) of the Internal Revenue Code, which agencies or institutions are located in areas of critical medical need or in medically underserved areas as determined pursuant to 42 U.S.C. s. 300e-1(7).

(d) ~~(4)~~ The board shall notify the director of the full-time local county health department of any county in which a licensee intends to practice under the provisions of this subsection ~~section~~. The director of the full-time county health department shall assist in the supervision of any licensee within the ~~her or his~~ county and shall notify the board if she or he becomes aware of any action by the licensee which would be a ground for revocation of the limited license. The board shall establish procedures for such supervision.

(e) ~~(5)~~ The ~~State~~ board ~~of Osteopathic Medicine~~ shall review the practice of each licensee under this subsection ~~section~~ biennially to verify compliance with the restrictions prescribed in this subsection ~~section~~ and other provisions of this chapter.

(f) ~~(6)~~ Any person holding an active license to practice osteopathic medicine in this ~~the~~ state may convert that license to a limited license under this subsection for the purpose of providing volunteer, uncompensated care for low-income Floridians. The applicant must submit a statement from the employing agency or institution stating that she or he ~~or she~~ will not receive compensation for any service involving the

practice of osteopathic medicine. The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for such applicant.

(2) GRADUATE ASSISTANT PHYSICIANS.— A graduate assistant physician is a medical school graduate who meets the requirements of this subsection and has obtained a limited license from the board for the purpose of practicing temporarily under the direct supervision of a physician who has a full, active, and unencumbered license issued under this chapter, pending the graduate's entrance into a residency under the National Resident Match Program.

(a) Any person desiring to obtain a limited license as a graduate assistant physician must submit to the board an application and demonstrate that she or he meets all of the following criteria:

1. Is a graduate of a school or college of osteopathic medicine approved by an accrediting agency recognized by the United States Department of Education.

2. Has successfully passed all parts of the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the board.

3. Has not received and accepted a residency match from the National Resident Matching Program within the first year following graduation from medical school.

(b) The board shall issue a graduate assistant physician

limited license for a duration of 2 years to an applicant who meets the requirements of paragraph (a) and all of the following criteria:

1. Is at least 21 years of age.

2. Is of good moral character.

3. Submits documentation that the applicant has agreed to enter into a written protocol drafted by a physician with a full, active, and unencumbered license issued under this chapter upon the board's issuance of a limited license to the applicant, and submits a copy of the protocol. The board shall establish by rule specific provisions that must be included in a physician-drafted protocol.

4. Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 459.015.

5. Has submitted to the department a set of fingerprints on a form and under procedures specified by the department.

6. The board may not certify to the department for limited licensure under this subsection any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter or chapter 456 until such investigation is completed. Upon completion of the investigation, s. 459.015 applies. Furthermore, the department may not issue a limited license to any individual who has committed any act or offense in any jurisdiction which would

constitute the basis for disciplining a physician under s. 459.015. If the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 459.015, the board may enter an order imposing one of the following terms:

a. Refusal to certify to the department an application for a graduate assistant physician limited license; or

b. Certification to the department of an application for a graduate assistant physician limited license with restrictions on the scope of practice of the licensee.

(c) A graduate assistant physician limited licensee may apply for a one-time renewal of his or her limited license by submitting a board-approved application, documentation of actual practice under the required protocol during the initial limited licensure period, and documentation of applications he or she has submitted for accredited graduate medical education training programs. The one-time renewal terminates after 1 year.

(d) A limited licensed graduate assistant physician may provide health care services only under the direct supervision of a physician with a full, active, and unencumbered license issued under this chapter.

(e) A physician must be approved by the board to supervise a limited licensed graduate assistant physician.

(f) A physician may supervise no more than two graduate assistant physicians with limited licenses.

(g) Supervision of limited licensed graduate assistant physicians requires the physical presence of the supervising physician at the location where the services are rendered.

(h) A physician-drafted protocol must specify the duties and responsibilities of the limited licensed graduate assistant physician according to criteria adopted by board rule.

(i) Each protocol that applies to a limited licensed graduate assistant physician and his or her supervising physician must ensure that:

1. There is a process for the evaluation of the limited licensed graduate assistant physicians' performance; and

2. The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the graduate assistant physician's level of competency.

(j) A limited licensed graduate assistant physician's prescriptive authority is governed by the physician-drafted protocol and criteria adopted by the board and may not exceed that of his or her supervising physician. Any prescriptions and orders issued by the graduate assistant physician must identify both the graduate assistant physician and the supervising physician.

(k) A physician who supervises a graduate assistant physician is liable for any acts or omissions of the graduate assistant physician acting under the physician's supervision and

control. Third-party payors may reimburse employers of graduate assistant physicians for covered services rendered by graduate assistant physicians.

(3) RULES.—The board may adopt rules to implement this section.

Section 52. Section 459.0076, Florida Statutes, is amended to read:

459.0076 Temporary certificate for practice in areas of critical need.—

(1) A physician or physician assistant who holds a valid license ~~is licensed~~ to practice in any jurisdiction of the United States~~, whose license is currently valid, and who pays an application fee of $300~~ may be issued a temporary certificate for practice in areas of critical need. A physician seeking such certificate must pay an application fee of $300.

(2) A temporary certificate may be issued under this section to a physician or physician assistant who will:

(a) ~~Will~~ Practice in an area of critical need;

(b) ~~Will~~ Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state; or

(c) ~~Will~~ Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

(3) The board ~~of Osteopathic Medicine~~ may issue a ~~this~~ temporary certificate subject to ~~with~~ the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied, as applicable.

(b) The board may administer an abbreviated oral examination to determine the physician's or physician assistant's competency, but a written regular examination is not required. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application

and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant has not actively practiced during the 3-year period immediately preceding the application ~~prior 3 years~~ and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate having reasonable restrictions that may include, but are not limited to, a requirement for the applicant to practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid only so long as the State Surgeon General determines that the reason for which it was issued remains a critical need to the state. The board ~~of Osteopathic Medicine~~ shall review each temporary certificateholder at least ~~not less than~~ annually to

ascertain that the certificateholder is complying with the minimum requirements of the Osteopathic Medical Practice Act and its adopted rules, as applicable to the certificateholder ~~are being complied with~~. If it is determined that the certificateholder is not meeting such minimum requirements ~~are not being met~~, the board must ~~shall~~ revoke such certificate or ~~shall~~ impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any physician or physician assistant who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this chapter until such time as the investigation is complete, at which time ~~the provisions of~~ s. 459.015 applies ~~apply~~.

(4) The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the physician or physician assistant will not receive any compensation for any health care services that he or she provides ~~service involving the practice of medicine~~.

Section 53. Section 464.009, Florida Statutes, is amended to read:

464.009 Licensure by endorsement.—

~~(1)~~ The department shall issue the appropriate license by endorsement to practice professional or practical nursing to an applicant who, upon applying to the department and remitting a fee set by the board not to exceed $100, demonstrates to the board that he or she meets the requirements for licensure by endorsement in s. 456.0145.~~:~~

~~(a) Holds a valid license to practice professional or practical nursing in another state or territory of the United States, provided that, when the applicant secured his or her original license, the requirements for licensure were substantially equivalent to or more stringent than those existing in Florida at that time;~~

~~(b) Meets the qualifications for licensure in s. 464.008 and has successfully completed a state, regional, or national examination which is substantially equivalent to or more stringent than the examination given by the department; or~~

~~(c) Has actively practiced nursing in another state, jurisdiction, or territory of the United States for 2 of the preceding 3 years without having his or her license acted against by the licensing authority of any jurisdiction. Applicants who become licensed pursuant to this paragraph must complete within 6 months after licensure a Florida laws and~~

~~rules course that is approved by the board. Once the department has received the results of the national criminal history check and has determined that the applicant has no criminal history, the appropriate license by endorsement shall be issued to the applicant.~~

~~(2) Such examinations and requirements from other states and territories of the United States shall be presumed to be substantially equivalent to or more stringent than those in this state. Such presumption shall not arise until January 1, 1980. However, the board may, by rule, specify states and territories the examinations and requirements of which shall not be presumed to be substantially equivalent to those of this state.~~

~~(3) An applicant for licensure by endorsement who is relocating to this state pursuant to his or her military-connected spouse's official military orders and who is licensed in another state that is a member of the Nurse Licensure Compact shall be deemed to have satisfied the requirements of subsection (1) and shall be issued a license by endorsement upon submission of the appropriate application and fees and completion of the criminal background check required under subsection (4).~~

~~(4) The applicant must submit to the department a set of fingerprints on a form and under procedures specified by the department, along with a payment in an amount equal to the costs incurred by the Department of Health for the criminal background check of the applicant. The Department of Health shall submit~~

~~the fingerprints provided by the applicant to the Florida Department of Law Enforcement for a statewide criminal history check, and the Florida Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history check of the applicant. The Department of Health shall review the results of the criminal history check, issue a license to an applicant who has met all of the other requirements for licensure and has no criminal history, and shall refer all applicants with criminal histories back to the board for determination as to whether a license should be issued and under what conditions.~~

~~(5) The department shall not issue a license by endorsement to any applicant who is under investigation in another state, jurisdiction, or territory of the United States for an act which would constitute a violation of this part or chapter 456 until such time as the investigation is complete, at which time the provisions of s. 464.018 shall apply.~~

~~(6) The department shall develop an electronic applicant notification process and provide electronic notification when the application has been received and when background screenings have been completed, and shall issue a license within 30 days after completion of all required data collection and verification. This 30-day period to issue a license shall be tolled if the applicant must appear before the board due to information provided on the application or obtained through~~

~~screening and data collection and verification procedures.~~

~~(7) A person holding an active multistate license in another state pursuant to s. 464.0095 is exempt from the requirements for licensure by endorsement in this section.~~

Section 54. Section 464.0121, Florida Statutes, is created to read:

464.0121 Temporary certificate for practice in areas of critical need.—

(1) An advanced practice registered nurse who is licensed to practice in any jurisdiction of the United States, whose license is currently valid, and who meets educational and training requirements established by the board may be issued a temporary certificate for practice in areas of critical need.

(2) A temporary certificate may be issued under this section to an advanced practice registered nurse who will:

(a) Practice in an area of critical need;

(b) Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or another agency or institution that is approved by the State Surgeon General and that provides health care services to meet the needs of underserved populations in this state; or

(c) Practice for a limited time to address critical health care specialty, demographic, or geographic needs relating to

this state's accessibility of health care services as determined by the State Surgeon General.

(3) The board may issue a temporary certificate under this section subject to the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices as part of his or her employment.

(b) The board may administer an abbreviated oral examination to determine the advanced practice registered nurse's competency, but may not require a written regular examination. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant

has not actively practiced during the 3-year period immediately preceding the application and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate imposing reasonable restrictions that may include, but are not limited to, a requirement that the applicant practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board, which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid only so long as the State Surgeon General maintains the determination that the critical need that supported the issuance of the temporary certificate remains a critical need to the state. The board shall review each temporary certificateholder at least annually to ascertain that the certificateholder is complying with the minimum requirements of the Nurse Practice Act and its adopted rules, as applicable to the certificateholder. If it is determined that the certificateholder is not meeting such minimum requirements, the

board must revoke such certificate or impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any advanced practice registered nurse who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this part until such time as the investigation is complete, at which time s. 464.018 applies.

(4) All licensure fees, including neurological injury compensation assessments, are waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the advanced practice registered nurse will not receive any compensation for any health care services that he or she provides.

Section 55. Paragraph (b) of subsection (3) of section 464.0123, Florida Statutes, is amended to read:

464.0123 Autonomous practice by an advanced practice registered nurse.—

(3) PRACTICE REQUIREMENTS.—

(b)1. In order to provide out-of-hospital intrapartum care, a certified nurse midwife engaged in the autonomous

practice of nurse midwifery must maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services. The policy must prescribe and require the use of an emergency plan-of-care form, which must be signed by the patient before admission to intrapartum care. At a minimum, the form must include all of the following:

a. The name and address of the closest hospital that provides maternity and newborn services.

b. Reasons for which transfer of care would be necessary, including the transfer-of-care conditions prescribed by board rule.

c. Ambulances or other emergency medical services that would be used to transport the patient in the event of an emergency.

2. If transfer of care is determined necessary by the certified nurse midwife or under the terms of the written policy, the certified nurse midwife must document all of the following information on the patient's emergency plan-of-care form:

a. The name, date of birth, and condition of the patient.

b. The gravidity and parity of the patient and the gestational age and condition of the fetus or newborn infant.

c. The reasons that necessitated the transfer of care.

d. A description of the situation, relevant clinical background, assessment, and recommendations.

e. The planned mode of transporting the patient to the receiving facility.

f. The expected time of arrival at the receiving facility.

3. Before transferring the patient, or as soon as possible during or after an emergency transfer, the certified nurse midwife shall provide the receiving provider with a verbal summary of the information specified in subparagraph 2. and make himself or herself immediately available for consultation. Upon transfer of the patient to the receiving facility, the certified nurse midwife must provide the receiving provider with the patient's emergency plan-of-care form as soon as practicable.

4. The certified nurse midwife shall provide the receiving provider, as soon as practicable, with the patient's prenatal records, including patient history, prenatal laboratory results, sonograms, prenatal care flow sheets, maternal fetal medical reports, and labor flow charting and current notations.

5. The board shall adopt rules to prescribe transfer-of-care conditions, monitor for excessive transfers, conduct reviews of adverse maternal and neonatal outcomes, and monitor the licensure of certified nurse midwives engaged in autonomous practice ~~must have a written patient transfer agreement with a hospital and a written referral agreement with a physician licensed under chapter 458 or chapter 459 to engage in nurse midwifery~~.

Section 56. Subsection (10) of section 464.019, Florida

Statutes, is amended to read:

464.019 Approval of nursing education programs.—

(10) IMPLEMENTATION STUDY.—The Florida Center for Nursing shall study the administration of this section and submit reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives annually by January 30~~, through January 30, 2025~~. The annual reports shall address the previous academic year; provide data on the measures specified in paragraphs (a) and (b), as such data becomes available; and include an evaluation of such data for purposes of determining whether this section is increasing the availability of nursing education programs and the production of quality nurses. The department and each approved program or accredited program shall comply with requests for data from the Florida Center for Nursing.

(a) The Florida Center for Nursing shall evaluate program-specific data for each approved program and accredited program conducted in the state, including, but not limited to:

1. The number of programs and student slots available.

2. The number of student applications submitted, the number of qualified applicants, and the number of students accepted.

3. The number of program graduates.

4. Program retention rates of students tracked from program entry to graduation.

5. Graduate passage rates on the National Council of State Boards of Nursing Licensing Examination.

6. The number of graduates who become employed as practical or professional nurses in the state.

(b) The Florida Center for Nursing shall evaluate the board's implementation of the:

1. Program application approval process, including, but not limited to, the number of program applications submitted under subsection (1), the number of program applications approved and denied by the board under subsection (2), the number of denials of program applications reviewed under chapter 120, and a description of the outcomes of those reviews.

2. Accountability processes, including, but not limited to, the number of programs on probationary status, the number of approved programs for which the program director is required to appear before the board under subsection (5), the number of approved programs terminated by the board, the number of terminations reviewed under chapter 120, and a description of the outcomes of those reviews.

(c) The Florida Center for Nursing shall complete an annual assessment of compliance by programs with the accreditation requirements of subsection (11), include in the assessment a determination of the accreditation process status for each program, and submit the assessment as part of the reports required by this subsection.

Section 57. Section 465.0075, Florida Statutes, is amended to read:

465.0075 Licensure by endorsement; requirements; fee.—

~~(1)~~ The department shall issue a license by endorsement to any applicant who applies to the department and remits a nonrefundable fee of not more than $100, as set by the board, and whom the board certifies has met the requirements for licensure by endorsement in s. 456.0145.~~:~~

~~(a) Has met the qualifications for licensure in s. 465.007(1)(b) and (c);~~

~~(b) Has obtained a passing score, as established by rule of the board, on the licensure examination of the National Association of Boards of Pharmacy or a similar nationally recognized examination, if the board certifies that the applicant has taken the required examination;~~

~~(c)1. Has submitted evidence of the active licensed practice of pharmacy, including practice in community or public health by persons employed by a governmental entity, in another jurisdiction for at least 2 of the immediately preceding 5 years or evidence of successful completion of board-approved postgraduate training or a board-approved clinical competency examination within the year immediately preceding application for licensure; or~~

~~2. Has completed an internship meeting the requirements of s. 465.007(1)(c) within the 2 years immediately preceding~~

~~application; and~~

~~(d) Has obtained a passing score on the pharmacy jurisprudence portions of the licensure examination, as required by board rule.~~

~~(2) An applicant licensed in another state for a period in excess of 2 years from the date of application for licensure in this state shall submit a total of at least 30 hours of board-approved continuing education for the 2 calendar years immediately preceding application.~~

~~(3) The department may not issue a license by endorsement to any applicant who is under investigation in any jurisdiction for an act or offense that would constitute a violation of this chapter until the investigation is complete, at which time the provisions of s. 465.016 apply.~~

~~(4) The department may not issue a license by endorsement to any applicant whose license to practice pharmacy has been suspended or revoked in another state or who is currently the subject of any disciplinary proceeding in another state.~~

Section 58. Subsection (1) of section 467.0125, Florida Statutes, is amended to read:

467.0125 Licensed midwives; qualifications; endorsement; temporary certificates.—

(1) The department shall issue a license by endorsement to practice midwifery to an applicant who~~, upon applying to the department,~~ demonstrates to the department that she or he meets

~~all of~~ the requirements for licensure by endorsement in s. 456.0145 and submits ~~following criteria:~~

~~(a) Holds an active, unencumbered license to practice midwifery in another state, jurisdiction, or territory, provided the licensing requirements of that state, jurisdiction, or territory at the time the license was issued were substantially equivalent to or exceeded those established under this chapter and the rules adopted hereunder.~~

~~(b) Has successfully completed a prelicensure course conducted by an accredited and approved midwifery program.~~

~~(c) Submits~~ an application for licensure on a form approved by the department and pays the appropriate fee.

Section 59. Subsection (4) of section 468.1705, Florida Statutes, is renumbered as subsection (3) and subsections (1), (2), and (3) of that section are amended, to read:

468.1705 Licensure by endorsement; temporary license.—

(1) The department shall issue a license by endorsement to any applicant who, upon applying to the department and remitting a fee set by the board not to exceed $500, demonstrates to the board that he or she meets the requirements for licensure by endorsement in s. 456.0145~~:~~

~~(a) Meets one of the following requirements:~~

~~1. Holds a valid active license to practice nursing home administration in another state of the United States, provided that the current requirements for licensure in that state are~~

~~substantially equivalent to, or more stringent than, current requirements in this state; or~~

~~2. Meets the qualifications for licensure in s. 468.1695;~~ ~~and~~

~~(b)1. Has successfully completed a national examination which is substantially equivalent to, or more stringent than, the examination given by the department;~~

~~2. Has passed an examination on the laws and rules of this state governing the administration of nursing homes; and~~

~~3. Has worked as a fully licensed nursing home administrator for 2 years within the 5-year period immediately preceding the application by endorsement.~~

~~(2) National examinations for licensure as a nursing home administrator shall be presumed to be substantially equivalent to, or more stringent than, the examination and requirements in this state, unless found otherwise by rule of the board~~.

(2)~~(3)~~ The department may ~~shall~~ not issue a ~~license by endorsement or a~~ temporary license to any applicant who is under investigation in this or another state for any act which would constitute a violation of this part until such time as the investigation is complete and disciplinary proceedings have been terminated.

Section 60. Section 468.213, Florida Statutes, is repealed.

Section 61. Section 468.3065, Florida Statutes, is amended

to read:

468.3065 Certification by endorsement.—

(1) The department may issue a certificate by endorsement to practice as a radiologist assistant to an applicant who, upon applying to the department and remitting a nonrefundable fee not to exceed $50, demonstrates to the department that he or she meets the requirements for licensure by endorsement in s. 456.0145 ~~holds a current certificate or registration as a radiologist assistant granted by the American Registry of Radiologic Technologists~~.

(2) The department may issue a certificate by endorsement to practice radiologic technology to an applicant who, upon applying to the department and remitting a nonrefundable fee not to exceed $50, demonstrates to the department that he or she meets the requirements for licensure by endorsement in s. 456.0145 ~~holds a current certificate, license, or registration to practice radiologic technology, provided that the requirements for such certificate, license, or registration are deemed by the department to be substantially equivalent to those established under this part and rules adopted under this part~~.

(3) The department may issue a certificate by endorsement to practice as a specialty technologist to an applicant who, upon applying to the department and remitting a nonrefundable fee not to exceed $100, demonstrates to the department that he or she meets the requirements for licensure by endorsement in s.

456.0145 ~~holds a current certificate or registration from a national organization in a particular advanced, postprimary, or specialty area of radiologic technology, such as computed tomography or positron emission tomography~~.

Section 62. Section 468.358, Florida Statutes, is repealed.

Section 63. Section 478.47, Florida Statutes, is amended to read:

478.47 Licensure by endorsement.—The department shall issue a license by endorsement to any applicant who, upon submitting ~~submits~~ an application and the required fees as set forth in s. 478.55, demonstrates to the board that he or she meets the requirements for licensure by endorsement in s. 456.0145 ~~and who holds an active license or other authority to practice electrology in a jurisdiction whose licensure requirements are determined by the board to be equivalent to the requirements for licensure in this state~~.

Section 64. Paragraph (c) of subsection (5) of section 480.041, Florida Statutes, is amended to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(5) The board shall adopt rules:

(c) Specifying licensing procedures for practitioners desiring to be licensed in this state who meet the requirements for licensure by endorsement in section 456.0145 or hold an

active license and have practiced in ~~any other state, territory, or jurisdiction of the United States or~~ any foreign national jurisdiction which has licensing standards substantially similar to, equivalent to, or more stringent than the standards of this state.

Section 65. Section 486.081, Florida Statutes, is amended to read:

486.081 Physical therapist; endorsement; ~~issuance of license without examination to person passing examination of another authorized examining board; fee~~.—

(1) The board may cause a license by endorsement to be issued through the department ~~without examination~~ to any applicant who presents evidence satisfactory to the board of meeting the requirements for licensure by endorsement in s. 456.0145 ~~having passed the American Registry Examination prior to 1971 or an examination in physical therapy before a similar lawfully authorized examining board of another state, the District of Columbia, a territory, or a foreign country, if the standards for licensure in physical therapy in such other state, district, territory, or foreign country are determined by the board to be as high as those of this state, as established by rules adopted pursuant to this chapter~~. Any person who holds a license pursuant to this section may use the words "physical therapist" or "physiotherapist" or the letters "P.T." in connection with her or his name or place of business to denote

her or his licensure hereunder. A person who holds a license pursuant to this section and obtains a doctoral degree in physical therapy may use the letters "D.P.T." and "P.T." A physical therapist who holds a degree of Doctor of Physical Therapy may not use the title "doctor" without also clearly informing the public of his or her profession as a physical therapist.

(2) At the time of making application for licensure by endorsement under ~~without examination pursuant to the terms of~~ this section, the applicant shall pay to the department a fee not to exceed $175 as fixed by the board, no part of which will be returned.

Section 66. Section 491.006, Florida Statutes, is amended to read:

491.006 Licensure or certification by endorsement.—

(1) The department shall license or grant a certificate to a person in a profession regulated by this chapter who, upon applying to the department and remitting the appropriate fee, demonstrates to the board that he or she meets the requirements for licensure by endorsement in s. 456.0145~~:~~

~~(a) Has demonstrated, in a manner designated by rule of the board, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.~~

~~(b)1. Holds an active valid license to practice and has~~

~~actively practiced the licensed profession in another state for 3 of the last 5 years immediately preceding licensure;~~

~~2. Has passed a substantially equivalent licensing examination in another state or has passed the licensure examination in this state in the profession for which the applicant seeks licensure; and~~

~~3. Holds a license in good standing, is not under investigation for an act that would constitute a violation of this chapter, and has not been found to have committed any act that would constitute a violation of this chapter~~.

The fees paid by any applicant for certification as a master social worker under this section are nonrefundable.

~~(2) The department shall not issue a license or certificate by endorsement to any applicant who is under investigation in this or another jurisdiction for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 491.009 shall apply.~~

(2)~~(3)~~ A person licensed as a clinical social worker, marriage and family therapist, or mental health counselor in another state who is practicing under the Professional Counselors Licensure Compact pursuant to s. 491.017, and only within the scope provided therein, is exempt from the licensure requirements of this section, as applicable.

Section 67. Section 458.3129, Florida Statutes, is created to read:

458.3129 Interstate Medical Licensure Compact.—A physician licensed to practice allopathic medicine under s. 456.4501 is deemed to also be licensed under this chapter.

Section 68. Section 459.074, Florida Statutes, is created to read:

459.074 Interstate Medical Licensure Compact.—A physician licensed to practice osteopathic medicine under s. 456.4501 is deemed to also be licensed under this chapter.

Section 69. Subsections (4), (5), and (6) of section 468.1135, Florida Statutes, are renumbered as subsections (5), (6), and (7), respectively, and a new subsection (4) is added to that section, to read:

468.1135 Board of Speech-Language Pathology and Audiology.—

(4) The board shall appoint two of its members to serve as the state's delegates on the Speech-Language Pathology Interstate Compact Commission, pursuant to s. 468.1335, one of whom must be an audiologist and one of whom must be a speech-language pathologist.

Section 70. Subsection (5) section 468.1185, Florida Statutes, is renumbered as subsection (3), subsections (3) and (4) are amended, and a new subsection (4) is added to that section, to read:

468.1185 Licensure.—

~~(3) The board shall certify as qualified for a license by endorsement as a speech-language pathologist or audiologist an applicant who:~~

~~(a) Holds a valid license or certificate in another state or territory of the United States to practice the profession for which the application for licensure is made, if the criteria for issuance of such license were substantially equivalent to or more stringent than the licensure criteria which existed in this state at the time the license was issued; or~~

~~(b) Holds a valid certificate of clinical competence of the American Speech-Language and Hearing Association or board certification in audiology from the American Board of Audiology.~~

(4) A person licensed as an audiologist or a speech-language pathologist in another state who is practicing under the Audiology and Speech-Language Pathology Interstate Compact pursuant to s. 468.1335, and only within the scope provided therein, is exempt from the licensure requirements of this section.

~~(4) The board may refuse to certify any applicant who is under investigation in any jurisdiction for an act which would constitute a violation of this part or chapter 456 until the investigation is complete and disciplinary proceedings have been terminated.~~

Section 71. Subsections (1) and (2) of section 468.1295,

Florida Statutes, are amended to read:

468.1295 Disciplinary proceedings.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2) or s. 468.1335:

(a) Procuring, or attempting to procure, a license by bribery, by fraudulent misrepresentation, or through an error of the department or the board.

(b) Having a license revoked, suspended, or otherwise acted against, including denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of speech-language pathology or audiology.

(d) Making or filing a report or record which the licensee knows to be false, intentionally or negligently failing to file a report or records required by state or federal law, willfully impeding or obstructing such filing, or inducing another person to impede or obstruct such filing. Such report or record shall include only those reports or records which are signed in one's capacity as a licensed speech-language pathologist or audiologist.

(e) Advertising goods or services in a manner which is fraudulent, false, deceptive, or misleading in form or content.

(f) Being proven guilty of fraud or deceit or of negligence, incompetency, or misconduct in the practice of speech-language pathology or audiology.

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

(h) Practicing with a revoked, suspended, inactive, or delinquent license.

(i) Using, or causing or promoting the use of, any advertising matter, promotional literature, testimonial, guarantee, warranty, label, brand, insignia, or other representation, however disseminated or published, which is misleading, deceiving, or untruthful.

(j) Showing or demonstrating or, in the event of sale, delivery of a product unusable or impractical for the purpose represented or implied by such action.

(k) Failing to submit to the board on an annual basis, or such other basis as may be provided by rule, certification of testing and calibration of such equipment as designated by the board and on the form approved by the board.

(l) Aiding, assisting, procuring, employing, or advising any licensee or business entity to practice speech-language pathology or audiology contrary to this part, chapter 456, or any rule adopted pursuant thereto.

(m) Misrepresenting the professional services available in the fitting, sale, adjustment, service, or repair of a hearing aid, or using any other term or title which might connote the availability of professional services when such use is not accurate.

(n) Representing, advertising, or implying that a hearing aid or its repair is guaranteed without providing full disclosure of the identity of the guarantor; the nature, extent, and duration of the guarantee; and the existence of conditions or limitations imposed upon the guarantee.

(o) Representing, directly or by implication, that a hearing aid utilizing bone conduction has certain specified features, such as the absence of anything in the ear or leading to the ear, or the like, without disclosing clearly and conspicuously that the instrument operates on the bone conduction principle and that in many cases of hearing loss this type of instrument may not be suitable.

(p) Stating or implying that the use of any hearing aid will improve or preserve hearing or prevent or retard the progression of a hearing impairment or that it will have any similar or opposite effect.

(q) Making any statement regarding the cure of the cause of a hearing impairment by the use of a hearing aid.

(r) Representing or implying that a hearing aid is or will be "custom-made," "made to order," or "prescription-made," or in

any other sense specially fabricated for an individual, when such is not the case.

(s) Canvassing from house to house or by telephone, either in person or by an agent, for the purpose of selling a hearing aid, except that contacting persons who have evidenced an interest in hearing aids, or have been referred as in need of hearing aids, shall not be considered canvassing.

(t) Failing to notify the department in writing of a change in current mailing and place-of-practice address within 30 days after such change.

(u) Failing to provide all information as described in ss. 468.1225(5)(b), 468.1245(1), and 468.1246.

(v) Exercising influence on a client in such a manner as to exploit the client for financial gain of the licensee or of a third party.

(w) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee or certificateholder knows, or has reason to know, the licensee or certificateholder is not competent to perform.

(x) Aiding, assisting, procuring, or employing any unlicensed person to practice speech-language pathology or audiology.

(y) Delegating or contracting for the performance of professional responsibilities by a person when the licensee

delegating or contracting for performance of such responsibilities knows, or has reason to know, such person is not qualified by training, experience, and authorization to perform them.

(z) Committing any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined pursuant to s. 468.1296.

(aa) Being unable to practice the profession for which he or she is licensed or certified under this chapter with reasonable skill or competence as a result of any mental or physical condition or by reason of illness, drunkenness, or use of drugs, narcotics, chemicals, or any other substance. In enforcing this paragraph, upon a finding by the State Surgeon General, his or her designee, or the board that probable cause exists to believe that the licensee or certificateholder is unable to practice the profession because of the reasons stated in this paragraph, the department shall have the authority to compel a licensee or certificateholder to submit to a mental or physical examination by a physician, psychologist, clinical social worker, marriage and family therapist, or mental health counselor designated by the department or board. If the licensee or certificateholder refuses to comply with the department's order directing the examination, such order may be enforced by filing a petition for enforcement in the circuit court in the circuit in which the licensee or certificateholder resides or

does business. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice for which he or she is licensed or certified with reasonable skill and safety to patients.

(bb) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

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

(b) The board may take adverse action against an audiologist's or a speech-language pathologist's compact privilege under the Audiology and Speech-Language Pathology Interstate Compact pursuant to s. 468.1335 and may impose any of the penalties in s. 456.072(2), if an audiologist or a speech-language pathologist commits an act specified in subsection (1) or s. 456.072(1).

Section 72. Section 468.1335, Florida Statutes, is created to read:

468.1335 Practice of Audiology and Speech-language Pathology Interstate Compact.—The Practice of Audiology and Speech-language Pathology Interstate Compact is hereby enacted

into law and entered into by this state with all other states legally joining therein in the form substantially as follows:

ARTICLE I

PURPOSE

(1) The purpose of the compact is to facilitate the interstate practice of audiology and speech-language pathology with the goal of improving public access to audiology and speech-language pathology services.

(2) The practice of audiology and speech-language pathology occurs in the state where the patient, client, or student is located at the time the services are provided.

(3) The compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

(4) The compact is designed to achieve all of the following objectives:

(a) Increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other member state licenses.

(b) Enhance the states' abilities to protect public health and safety.

(c) Encourage the cooperation of member states in regulating multistate audiology and speech-language pathology

practices.

(d) Support spouses of relocating active duty military personnel.

(e) Enhance the exchange of licensure, investigative, and disciplinary information between member states.

(f) Allow a remote state to hold a licensee with compact privilege in that state accountable to that state's practice standards.

(g) Allow for the use of telehealth technology to facilitate increased access to audiology and speech-language pathology services.

ARTICLE II

DEFINITIONS

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

(2) "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. chapters 1209 and 1211.

(3) "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board against a licensee, including actions against an individual's license or privilege to practice such as revocation, suspension, probation, monitoring of the

licensee, or restriction on the licensee's practice.

(4) "Alternative program" means a nondisciplinary monitoring process approved by an audiology licensing board or a speech-language pathology licensing board to address impaired licensees.

(5) "Audiologist" means an individual who is licensed by a state to practice audiology.

(6) "Audiology" means the care and services provided by a licensed audiologist as provided in the member state's rules and regulations.

(7) "Audiology and Speech-language Pathology Interstate Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

(8) "Audiology licensing board" means the agency of a state that is responsible for the licensing and regulation of audiologists.

(9) "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as an audiologist or speech-language pathologist in the remote state under its rules and regulations. The practice of audiology or speech-language pathology occurs in the member state where the patient, client, or student is located at the time the services are provided.

(10) "Current significant investigative information,"

"investigative materials," "investigative records," or "investigative reports" means information that a licensing board, after an inquiry or investigation that includes notification and an opportunity for the audiologist or speech-language pathologist to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.

(11) "Data system" means a repository of information relating to licensees, including, but not limited to, continuing education, examination, licensure, investigative, compact privilege, and adverse action information.

(12) "Encumbered license" means a license in which an adverse action restricts the practice of audiology or speech-language pathology by the licensee and the adverse action has been reported to the National Practitioner Data Bank (NPDB).

(13) "Executive committee" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(14) "Home state" means the member state that is the licensee's primary state of residence.

(15) "Impaired licensee" means a licensee whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions.

(16) "Licensee" means a person who is licensed by his or her home state to practice as an audiologist or speech-language

pathologist.

(17) "Licensing board" means the agency of a state that is responsible for the licensing and regulation of audiologists or speech-language pathologists.

(18) "Member state" means a state that has enacted the compact.

(19) "Privilege to practice" means the legal authorization to practice audiology or speech-language pathology in a remote state.

(20) "Remote state" means a member state other than the home state where a licensee is exercising or seeking to exercise his or her compact privilege.

(21) "Rule" means a regulation, principle, or directive adopted by the commission that has the force of law.

(22) "Single-state license" means an audiology or speech-language pathology license issued by a member state that authorizes practice only within the issuing state and does not include a privilege to practice in any other member state.

(23) "Speech-language pathologist" means an individual who is licensed to practice speech-language pathology.

(24) "Speech-language pathology" means the care and services provided by a licensed speech-language pathologist as provided in the member state's rules and regulations.

(25) "Speech-language pathology licensing board" means the agency of a state that is responsible for the licensing and

regulation of speech-language pathologists.

(26) "State" means any state, commonwealth, district, or territory of the United States of America that regulates the practice of audiology and speech-language pathology.

(27) "State practice laws" means a member state's laws, rules, and regulations that govern the practice of audiology or speech-language pathology, define the scope of audiology or speech-language pathology practice, and create the methods and grounds for imposing discipline.

(28) "Telehealth" means the application of telecommunication technology to deliver audiology or speech-language pathology services at a distance for assessment, intervention, or consultation.

ARTICLE III

STATE PARTICIPATION

(1) A license issued to an audiologist or speech-language pathologist by a home state to a resident in that state must be recognized by each member state as authorizing an audiologist or speech-language pathologist to practice audiology or speech-language pathology, under a privilege to practice, in each member state.

(2) A state must implement procedures for considering the criminal history records of applicants for initial privilege to

practice. These procedures must include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history records from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal history records.

(a) A member state must fully implement a criminal history records check procedure, within a timeframe established by rule, which requires the member state to receive an applicant's criminal history records from the Federal Bureau of Investigation and the agency responsible for retaining the member state's criminal history records and use such records in making licensure decisions.

(b) Communication between a member state, the commission, and other member states regarding the verification of eligibility for licensure through the compact may not include any information received from the Federal Bureau of Investigation relating to a criminal history records check performed by a member state under Pub. L. No. 92-544.

(3) Upon application for a privilege to practice, the licensing board in the issuing remote state must determine, through the data system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or privilege to practice held by the applicant, and whether any adverse action has been taken against any license or privilege to practice held

by the applicant.

(4) Each member state must require an applicant to obtain or retain a license in his or her home state and meet the home state's qualifications for licensure or renewal of licensure and all other applicable state laws.

(5) Each member state must require that an applicant meet all of the following criteria to receive the privilege to practice as an audiologist in the member state:

(a) One of the following educational requirements:

1. On or before December 31, 2007, has graduated with a master's degree or doctoral degree in audiology, or an equivalent degree, regardless of the name of such degree, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or

2. On or after January 1, 2008, has graduated with a doctoral degree in audiology, or an equivalent degree, regardless of the name of such degree, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or

3. Has graduated from an audiology program that is housed in an institution of higher education outside of the United States for which the degree program and institution have been approved by the authorized accrediting body in the applicable country and the degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.

(b) Has completed a supervised clinical practicum experience from an accredited educational institution or its cooperating programs as required by the commission.

(c) Has successfully passed a national examination approved by the commission.

(d) Holds an active, unencumbered license.

(e) Has not been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession.

(f) Has a valid United States social security number or a national provider identifier number.

(6) Each member state must require that an applicant meet all of the following criteria to receive the privilege to practice as a speech-language pathologist in the member state:

(a) One of the following educational requirements:

1. Has graduated with a master's degree from a speech-

language pathology program that is accredited by an organization recognized by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or

2. Has graduated from a speech-language pathology program that is housed in an institution of higher education outside of the United States for which the degree program and institution have been approved by the authorized accrediting body in the applicable country and the degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.

(b) Has completed a supervised clinical practicum experience from an educational institution or its cooperating programs as required by the commission.

(c) Has completed a supervised postgraduate professional experience as required by the commission.

(d) Has successfully passed a national examination approved by the commission.

(e) Holds an active, unencumbered license.

(f) Has not been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession.

(g) Has a valid United States social security number or

national provider identifier number.

(7) The privilege to practice is derived from the home state license.

(8) An audiologist or speech-language pathologist practicing in a member state must comply with the state practice laws of the member state where the client is located at the time service is provided. The practice of audiology and speech-language pathology includes all audiology and speech-language pathology practices as defined by the state practice laws of the member state where the client is located. The practice of audiology and speech-language pathology in a member state under a privilege to practice subjects an audiologist or speech-language pathologist to the jurisdiction of the licensing boards, courts, and laws of the member state where the client is located at the time service is provided.

(9) Individuals not residing in a member state shall continue to be able to apply for a member state's single-state license as provided under the laws of each member state. However, the single-state license granted to these individuals may not be recognized as granting the privilege to practice audiology or speech-language pathology in any other member state. The compact does not affect the requirements established by a member state for the issuance of a single-state license.

(10) Member states may charge a fee for granting a compact privilege.

(11) Member states must comply with the bylaws and rules of the commission.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise compact privilege under the compact, the audiologist or speech-language pathologist must meet all of the following criteria:

(a) Hold an active license in the home state.

(b) Have no encumbrance on any state license.

(c) Be eligible for compact privilege in any member state in accordance with Article III.

(d) Not have any adverse action against any license or compact privilege within the 2 years preceding the date of application.

(e) Notify the commission that he or she is seeking compact privilege within a remote state or states.

(f) Pay any applicable fees, including any state fee, for the compact privilege.

(g) Report to the commission any adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) For the purposes of compact privilege, an audiologist or speech-language pathologist may only hold one home state

license at a time.

(3) Except as provided in Article VI, if an audiologist or speech-language pathologist changes his or her primary state of residence by moving between two member states, the audiologist or speech-language pathologist must apply for licensure in the new home state, and the license issued by the prior home state shall be deactivated in accordance with applicable rules adopted by the commission.

(4) The audiologist or speech-language pathologist may apply for licensure in advance of a change in his or her primary state of residence.

(5) A license may not be issued by the new home state until the audiologist or speech-language pathologist provides satisfactory evidence of a change in his or her primary state of residence to the new home state and satisfies all applicable requirements to obtain a license from the new home state.

(6) If an audiologist or speech-language pathologist changes his or her primary state of residence by moving from a member state to a nonmember state, the license issued by the prior home state shall convert to a single-state license, valid only in the former home state.

(7) Compact privilege is valid until the expiration date of the home state license. The licensee must comply with the requirements of subsection (1) to maintain compact privilege in the remote state.

(8) A licensee providing audiology or speech-language pathology services in a remote state under compact privilege shall function within the laws and regulations of the remote state.

(9) A remote state may, in accordance with due process and state law, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, or take any other necessary actions to protect the health and safety of its residents.

(10) If a home state license is encumbered, the licensee shall lose compact privilege in all remote states until both of the following occur:

(a) The home state license is no longer encumbered.

(b) Two years have lapsed from the date of the adverse action.

(11) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain compact privilege in any remote state.

(12) Once the requirements of subsection (10) have been met, the licensee must meet the requirements in subsection (1) to obtain compact privilege in a remote state.

ARTICLE V

COMPACT PRIVILEGE TO PRACTICE TELEHEALTH

Member states shall recognize the right of an audiologist or speech-language pathologist, licensed by a home state in accordance with Article III and under rules adopted by the commission, to practice audiology or speech-language pathology in any member state through the use of telehealth under privilege to practice as provided in the compact and rules adopted by the commission.

ARTICLE VI

ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES

Active duty military personnel, or their spouses, as applicable, shall designate a home state where the individual has a current license in good standing. The individual may retain the home state designation during the period the servicemember is on active duty. Subsequent to designating a home state, the individual shall only change his or her home state only through application for licensure in the new state.

ARTICLE VII

ADVERSE ACTIONS

(1) In addition to the other powers conferred by state law, a remote state may:

(a) Take adverse action against an audiologist's or speech-language pathologist's privilege to practice within that member state.

1. Only the home state has the power to take adverse action against an audiologist's or a speech-language pathologist's license issued by the home state.

2. For purposes of taking adverse action, the home state shall give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

(b) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board in a member state for the attendance and testimony of witnesses or the production of evidence from another member state must be enforced in the latter state by any court of competent jurisdiction according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state in which the witnesses or evidence are located.

(c) Complete any pending investigations of an audiologist or speech-language pathologist who changes his or her primary

state of residence during the course of the investigations. The home state also has the authority to take appropriate actions and shall promptly report to the administrator of the data system the conclusions of the investigations. The administrator of the data system shall promptly notify the new home state of any adverse actions.

(d) If otherwise allowed by state law, recover from the affected audiologist or speech-language pathologist the costs of investigations and disposition of cases resulting from any adverse action taken against that audiologist or speech-language pathologist.

(e) Take adverse action based on the factual findings of the remote state, provided that the member state follows the member state's own procedures for taking the adverse action.

(2)(a) In addition to the authority granted to a member state by its respective audiology or speech-language pathology practice act or other applicable state law, any member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

(3) If adverse action is taken by the home state against an audiologist's or a speech language pathologist's license, the audiologist's or speech-language pathologist's privilege to

practice in all other member states shall be deactivated until all encumbrances have been removed from the home state license. All home state disciplinary orders that impose adverse action against an audiologist's or a speech language pathologist's license must include a statement that the audiologist's or speech-language pathologist's privilege to practice is deactivated in all member states during the pendency of the order.

(4) If a member state takes adverse action, it must promptly notify the administrator of the data system. The administrator of the data system shall promptly notify the home state of any adverse actions by remote states.

(5) The compact does not override a member state's decision that participation in an alternative program may be used in lieu of adverse action.

ARTICLE VIII

ESTABLISHMENT OF THE AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY INTERSTATE COMPACT COMMISSION

(1) The member states hereby create and establish a joint public agency known as the Audiology and Speech-language Pathology Interstate Compact Commission.

(a) The commission is an instrumentality of the compact states.

(b) Venue is proper, and judicial proceedings by or against the commission must be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) This compact does not waive sovereign immunity except to the extent sovereign immunity is waived in the member states.

(2)(a) Each member state must have two delegates selected by that member state's licensing boards. The delegates must be current members of the licensing boards. One delegate must be an audiologist and one delegate must be a speech-language pathologist.

(b) An additional five delegates, who are either public members or board administrators from licensing boards, must be chosen by the executive committee from a pool of nominees provided by the commission at large.

(c) A delegate may be removed or suspended from office as provided by the state law from which the delegate is appointed.

(d) The member state board shall fill any vacancy occurring on the commission within 90 days after the vacancy occurs.

(e) Each delegate is entitled to one vote with regard to the adoption of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs

of the commission.

(f) A delegate shall vote in person or by other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(g) The commission shall meet at least once during each calendar year. Additional meetings must be held as provided in the bylaws and rules.

(3) The commission has the following powers and duties:

(a) Establish the commission's fiscal year.

(b) Establish bylaws.

(c) Establish a code of ethics.

(d) Maintain its financial records in accordance with the bylaws.

(e) Meet and take actions as are consistent with the compact and the bylaws.

(f) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules shall have the force and effect of law and are binding on all member states.

(g) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of an audiology licensing board or a speech-language pathology licensing board to sue or be sued under applicable law is not affected.

(h) Purchase and maintain insurance and bonds.

(i) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(j) Hire employees, elect or appoint officers, fix compensation, define duties, grant individuals appropriate authority to carry out the purposes of the compact, and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(k) Accept any appropriate donations and grants of money, equipment, supplies, and materials and services, and receive, use, and dispose of the same, provided that at all times the commission must avoid any appearance of impropriety or conflict of interest.

(l) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission shall avoid any appearance of impropriety.

(m) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed.

(n) Establish a budget and make expenditures.

(o) Borrow money.

(p) Appoint committees, including standing committees composed of members, and other interested persons as may be

designated in the compact and the bylaws.

(q) Provide and receive information from, and cooperate with, law enforcement agencies.

(r) Establish and elect an executive committee.

(s) Perform other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of audiology and speech-language pathology licensure and practice.

(4) The executive committee shall have the power to act on behalf of the commission according to the terms of the compact.

(a) The executive committee must be composed of 10 members as follows:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. Two ex officio members, consisting of one nonvoting member from a recognized national audiology professional association and one nonvoting member from a recognized national speech-language pathology association.

3. One ex-officio, nonvoting member from the recognized membership organization of the audiology licensing and speech-language pathology licensing boards.

(b) The ex officio members must be selected by their respective organizations.

(c) The commission may remove any member of the executive committee as provided in the bylaws.

(d) The executive committee shall meet at least annually.

(e) The executive committee has the following duties and responsibilities:

1. Recommend to the entire commission changes to the rules or bylaws and changes to this compact legislation, fees paid by member states such as annual dues, and any commission compact fee charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractual or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Other duties as provided by rule or bylaw.

(f) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in Article X.

(g) If a meeting or any portion of a meeting is closed under this subsection, the commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(h) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the

reasons therefore, including a description of the views expressed. All documents considered in connection with an action must be identified in minutes. All minutes and documents of a closed meeting must remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

(5) Relating to the financing of the commission, the commission:

(a) Shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) May accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) May levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the commission, which shall promulgate a rule binding upon all member states.

(d) May not incur obligations of any kind before securing the funds adequate to meet the same and may not pledge the

credit of any of the member states, except by and with the authority of the member state.

(e) Shall keep accurate accounts of all receipts and disbursements of funds. The receipts and disbursements of funds of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(6) Relating to qualified immunity, defense, and indemnification:

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that this paragraph does not protect any person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(b) The commission shall defend any member, officer,

executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that this paragraph may not be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

ARTICLE IX

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and current significant investigative information on all licensed individuals in member states.

(2) Notwithstanding any other law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission, including all of the following information:

(a) Identifying information.

(b) Licensure data.

(c) Adverse actions against a license or compact privilege.

(d) Nonconfidential information related to alternative program participation.

(e) Any denial of application for licensure, and the reason for such denial.

(f) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Current significant investigative information pertaining to a licensee in a member state must be available

only to other member states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee or an individual applying for a license in any member state must be available to any other member state.

(5) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

(6) Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE X

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria provided in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, the rule has no further force and

effect in any member state.

(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule or rules by the commission, and at least 30 days before the meeting at which the rule shall be considered and voted upon, the commission shall file a notice of proposed rulemaking:

(a) On the website of the commission or other publicly accessible platform; and

(b) On the website of each member state audiology licensing board and speech-language pathology licensing board or other publicly accessible platform or the publication where each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon.

(b) The text of and reason for the proposed rule or amendment.

(c) A request for comments on the proposed rule from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before the adoption of a proposed rule, the commission

shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(a) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least 25 persons;

2. A state or federal governmental subdivision or agency; or

3. An association having at least 25 members.

(b) If a hearing is held on the proposed rule or amendment, the commission must publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the commission must publish the mechanism for access to the electronic hearing.

(c) All persons wishing to be heard at the hearing shall notify the executive director of the commission or other designated member in writing of their desire to appear and testify at the hearing not less than 5 business days before the scheduled date of the hearing.

(d) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(e) All hearings must be recorded. A copy of the recording must be made available on request.

(7) This article does not require a separate hearing on

each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(8) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(9) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public hearing.

(10) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(11) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this article retroactively apply to the rule as soon as reasonably possible, but in no event later than 90 days after the effective date of the rule. For purposes of this subsection, an emergency rule is one that must be adopted immediately in order to:

(a) Meet an imminent threat to public health, safety, or welfare;

(b) Prevent a loss of commission or member state funds; or

(c) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.

(12) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of the commission. The revisions are subject to challenge by any person for a period of 30 days after posting. A revision may be challenged only on grounds that it results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the commission before the end of the notice period. If no challenge is made, the revision takes effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE XI

DISPUTE RESOLUTION

AND ENFORCEMENT

(1)(a) Upon request by a member state, the commission shall attempt to resolve disputes related to the compact that arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(2)(a) The commission, in the reasonable exercise of its discretion, shall enforce the compact.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member must be awarded all costs of litigation, including reasonable attorney fees.

(c) The remedies provided in this subsection are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XII

EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

(1) The compact becomes effective and binding on the date of legislative enactment of the compact by no fewer than 10 member states. The provisions, which become effective at that time, shall be limited to the powers granted to the commission

relating to assembly and the adoption of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary to implement and administer the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) A member state may withdraw from the compact by enacting a statute repealing the compact.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's audiology licensing board or speech-language pathology licensing board to comply with the investigative and adverse action reporting requirements of the compact before the effective date of withdrawal.

(4) The compact does not invalidate or prevent any audiology or speech-language pathology licensure agreement or other cooperative arrangement between a member state and a nonmember state that does not conflict with the provisions of this compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding

upon any member state until it is enacted into the laws of all member states.

ARTICLE XIII

CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to effectuate its purposes. The provisions of the compact are severable and if any phrase, clause, sentence, or provision of this compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected. If the compact is held contrary to the constitution of any member state, the compact shall remain in full force and effect as to the remaining member states and in full force and effect as to the member state affected as to all severable matters.

ARTICLE XIV

BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) The compact does not prevent the enforcement of any other law of a member state that is not inconsistent with the

compact.

(2) All laws of a member state in conflict with the compact are superseded to the extent of the conflict.

(3) All lawful actions of the commission, including all rules and bylaws adopted by the commission, are binding upon the member states.

(4) All agreements between the commission and the member states are binding in accordance with their terms.

(5) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, the provision is ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 73. The provisions of the Audiology and Speech-Language Pathology Interstate Compact do not authorize the Department of Health or the Board of Speech-Language Pathology and Audiology to collect a compact privilege fee, but rather state that fees of this kind are allowable under the compact. The Department of Health and the Board of Speech-Language Pathology and Audiology must comply with the requirements of s. 456.025.

Section 74. Section 486.028, Florida Statutes, is amended to read:

486.028 License to practice physical therapy required.—A ~~No~~ person may not ~~shall~~ practice, or hold herself or himself out

as being able to practice, physical therapy in this state unless she or he is licensed under ~~in accordance with the provisions of~~ this chapter or holds a compact privilege in this state under the Physical Therapy Licensure Compact as specified in s. 486.112.~~; however, Nothing in~~ This chapter does not ~~shall~~ prohibit any person licensed in this state under any other law from engaging in the practice for which she or he is licensed.

Section 75. Section 486.031, Florida Statutes, is amended to read:

486.031 Physical therapist; licensing requirements; exemption.—

(1) To be eligible for licensing as a physical therapist, an applicant must:

(a) ~~(1)~~ Be at least 18 years old;

(b) ~~(2)~~ Be of good moral character; and

(c)1. ~~(3)(a)~~ Have ~~been~~ graduated from a school of physical therapy which has been approved for the educational preparation of physical therapists by the appropriate accrediting agency recognized by the Council for Higher Education Accreditation or its successor ~~Commission on Recognition of Postsecondary Accreditation~~ or the United States Department of Education at the time of her or his graduation and have passed, to the satisfaction of the board, the American Registry Examination before ~~prior to~~ 1971 or a national examination approved by the board to determine her or his fitness for practice as a physical

therapist under this chapter ~~as hereinafter provided~~;

2.~~(b)~~ Have received a diploma from a program in physical therapy in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapists in this country, as recognized by the appropriate agency as identified by the board, and have passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist under this chapter ~~as hereinafter provided~~; or

3.~~(c)~~ Be entitled to licensure without examination as provided in s. 486.081.

(2) A person licensed as a physical therapist in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 76. Section 486.102, Florida Statutes, is amended to read:

486.102 Physical therapist assistant; licensing requirements; exemption.—

(1) To be eligible for licensing by the board as a physical therapist assistant, an applicant must:

(a)~~(1)~~ Be at least 18 years old;

(b)~~(2)~~ Be of good moral character; and

(c)1.~~(3)(a)~~ Have ~~been~~ graduated from a school providing

~~giving~~ a course of at least ~~not less than~~ 2 years for physical therapist assistants, which has been approved for the educational preparation of physical therapist assistants by the appropriate accrediting agency recognized by the Council for Higher Education Accreditation or its successor ~~Commission on Recognition of Postsecondary Accreditation~~ or the United States Department of Education, at the time of her or his graduation and have passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist assistant under this chapter ~~as hereinafter provided~~;

2.~~(b)~~ Have ~~been~~ graduated from a school providing ~~giving~~ a course for physical therapist assistants in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapist assistants in this country, as recognized by the appropriate agency as identified by the board, and passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist assistant under this chapter ~~as hereinafter provided~~;

3.~~(c)~~ Be entitled to licensure without examination as provided in s. 486.107; or

4.~~(d)~~ Have been enrolled between July 1, 2014, and July 1, 2016, in a physical therapist assistant school in this state which was accredited at the time of enrollment; and

a.~~1.~~ Have ~~been~~ graduated or be eligible to graduate from

such school no later than July 1, 2018; and

b.~~2.~~ Have passed to the satisfaction of the board an examination to determine his or her fitness for practice as a physical therapist assistant as provided in s. 486.104.

(2) A person licensed as a physical therapist assistant in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 77. Section 486.107, Florida Statutes, is amended to read:

486.107 Physical therapist assistant; endorsement ~~issuance of license without examination to person licensed in another jurisdiction~~; fee.—

(1) The board may cause a license by endorsement to be issued through the department ~~without examination~~ to any applicant who presents evidence to the board, under oath, of meeting the requirements for licensure by endorsement in s. 456.0145 ~~licensure in another state, the District of Columbia, or a territory, if the standards for registering as a physical therapist assistant or licensing of a physical therapist assistant, as the case may be, in such other state are determined by the board to be as high as those of this state, as established by rules adopted pursuant to this chapter~~. Any person who holds a license pursuant to this section may use the

words "physical therapist assistant," or the letters "P.T.A.," in connection with her or his name to denote licensure hereunder.

(2) At the time of filing an ~~making~~ application for licensing by endorsement under ~~without examination pursuant to the terms of~~ this section, the applicant shall pay to the department a nonrefundable fee not to exceed $175, as determined ~~fixed~~ by the board~~, no part of which will be returned~~.

(3) A person licensed as a physical therapist assistant in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 78. Section 490.006, Florida Statutes, is amended to read:

490.006 Licensure by endorsement.—

(1) The department shall license a person as a psychologist or school psychologist who, upon applying to the department and remitting the appropriate fee, demonstrates to the department or, in the case of psychologists, to the board that the applicant meets the requirements for licensure by endorsement in s. 456.0145.~~:~~

~~(a) Is a diplomate in good standing with the American Board of Professional Psychology, Inc.; or~~

~~(b) Possesses a doctoral degree in psychology and has at~~

~~least 10 years of experience as a licensed psychologist in any jurisdiction or territory of the United States within the 25 years preceding the date of application.~~

~~(2) In addition to meeting the requirements for licensure set forth in subsection (1), an applicant must pass that portion of the psychology or school psychology licensure examinations pertaining to the laws and rules related to the practice of psychology or school psychology in this state before the department may issue a license to the applicant.~~

~~(3) The department shall not issue a license by endorsement to any applicant who is under investigation in this or another jurisdiction for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 490.009 shall apply.~~

(2)~~(4)~~ A person licensed as a psychologist in another state who is practicing pursuant to the Psychology Interjurisdictional Compact under s. 490.0075, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 79. Section 486.112, Florida Statutes, is created to read:

486.112 Physical Therapy Licensure Compact.—The Physical Therapy Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining

therein in the form substantially as follows:

ARTICLE I

PURPOSE AND OBJECTIVES

(1) The purpose of the compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The compact preserves the regulatory authority of member states to protect public health and safety through their current systems of state licensure. For purposes of state regulation under the compact, the practice of physical therapy is deemed to have occurred in the state where the patient is located at the time physical therapy is provided to the patient.

(2) The compact is designed to achieve all of the following objectives:

(a) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses.

(b) Enhance the states' ability to protect the public's health and safety.

(c) Encourage the cooperation of member states in regulating multistate physical therapy practice.

(d) Support spouses of relocating military members.

(e) Enhance the exchange of licensure, investigative, and

disciplinary information between member states.

(f) Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

ARTICLE II

DEFINITIONS

As used in the compact, and except as otherwise provided, the term:

(1) "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. chapter 1209 or chapter 1211.

(2) "Adverse action" means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

(3) "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a state's physical therapy licensing board. The term includes, but is not limited to, programs that address substance abuse issues.

(4) "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or physical therapist assistant in the remote state under its laws and rules.

(5) "Continuing competence" means a requirement, as a condition of license renewal, to provide evidence of participation in, and completion of, educational and professional activities relevant to the practice of physical therapy.

(6) "Data system" means the coordinated database and reporting system created by the Physical Therapy Compact Commission for the exchange of information between member states relating to licensees or applicants under the compact, including identifying information, licensure data, investigative information, adverse actions, nonconfidential information related to alternative program participation, any denials of applications for licensure, and other information as specified by commission rule.

(7) "Encumbered license" means a license that a physical therapy licensing board has limited in any way.

(8) "Executive board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(9) "Home state" means the member state that is the licensee's primary state of residence.

(10) "Investigative information" means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

(11) "Jurisprudence requirement" means the assessment of

an individual's knowledge of the laws and rules governing the practice of physical therapy in a specific state.

(12) "Licensee" means an individual who currently holds an authorization from a state to practice as a physical therapist or physical therapist assistant.

(13) "Member state" means a state that has enacted the compact.

(14) "Physical therapist" means an individual licensed by a state to practice physical therapy.

(15) "Physical therapist assistant" means an individual licensed by a state to assist a physical therapist in specified areas of physical therapy.

(16) "Physical therapy" or "the practice of physical therapy" means the care and services provided by or under the direction and supervision of a licensed physical therapist.

(17) "Physical Therapy Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

(18) "Physical therapy licensing board" means the agency of a state which is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

(19) "Remote state" means a member state other than the home state where a licensee is exercising or seeking to exercise the compact privilege.

(20) "Rule" means a regulation, principle, or directive

adopted by the commission which has the force of law.

(21) "State" means any state, commonwealth, district, or territory of the United States of America which regulates the practice of physical therapy.

ARTICLE III

STATE PARTICIPATION IN THE COMPACT

(1) To participate in the compact, a state must do all of the following:

(a) Participate fully in the commission's data system, including using the commission's unique identifier, as defined by commission rule.

(b) Have a mechanism in place for receiving and investigating complaints about licensees.

(c) Notify the commission, in accordance with the terms of the compact and rules, of any adverse action or the availability of investigative information regarding a licensee.

(d) Fully implement a criminal background check requirement, within a timeframe established by commission rule, which uses results from the Federal Bureau of Investigation record search on criminal background checks to make licensure decisions in accordance with subsection (2).

(e) Comply with the commission's rules.

(f) Use a recognized national examination as a requirement

for licensure pursuant to the commission's rules.

(g) Have continuing competence requirements as a condition for license renewal.

(2) Upon adoption of the compact, a member state has the authority to obtain biometric-based information from each licensee applying for a compact privilege and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. s. 534 and 34 U.S.C. s. 40316.

(3) A member state must grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

(4) Member states may charge a fee for granting a compact privilege.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise the compact privilege under the compact, a licensee must satisfy all of the following conditions:

(a) Hold a license in the home state.

(b) Not have an encumbrance on any state license.

(c) Be eligible for a compact privilege in all member states in accordance with subsections (4), (7), and (8).

(d) Not have had an adverse action against any license or

compact privilege within the preceding 2 years.

(e) Notify the commission that the licensee is seeking the compact privilege within a remote state.

(f) Pay any applicable fees, including any state fee, for the compact privilege.

(g) Meet any jurisprudence requirements established by the remote state in which the licensee is seeking a compact privilege.

(h) Report to the commission adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) The compact privilege is valid until the expiration date of the home license. The licensee must continue to meet the requirements of subsection (1) to maintain the compact privilege in a remote state.

(3) A licensee providing physical therapy in a remote state under the compact privilege must comply with the laws and rules of the remote state.

(4) A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege

in any member state until the specific period of time for removal has ended and all fines are paid.

(5) If a home state license is encumbered, the licensee loses the compact privilege in any remote state until the following conditions are met:

(a) The home state license is no longer encumbered.

(b) Two years have elapsed from the date of the adverse action.

(6) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in any remote state.

(7) If a licensee's compact privilege in any remote state is removed, the licensee loses the compact privilege in all remote states until all of the following conditions are met:

(a) The specific period of time for which the compact privilege was removed has ended.

(b) All fines have been paid.

(c) Two years have elapsed from the date of the adverse action.

(8) Once the requirements of subsection (7) have been met, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in a remote state.

ARTICLE V

ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may choose any of the following locations to designate his or her home state:

(1) Home of record.

(2) Permanent change of station location.

(3) State of current residence, if it is different from the home of record or permanent change of station location.

ARTICLE VI

ADVERSE ACTIONS

(1) A home state has exclusive power to impose adverse action against a license issued by the home state.

(2) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

(3) The compact does not override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation remain nonpublic if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without

prior authorization from such other member state.

(4) A member state may investigate actual or alleged violations of the laws and rules for the practice of physical therapy committed in any other member state by a physical therapist or physical therapist assistant practicing under the compact who holds a license or compact privilege in such other member state.

(5) A remote state may do any of the following:

(a) Take adverse actions as set forth in subsection (4) of article IV against a licensee's compact privilege in the state.

(b) Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a physical therapy licensing board in a member state for the attendance and testimony of witnesses or for the production of evidence from another member state must be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service laws of the state where the witnesses or evidence is located.

(c) If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

(6)(a) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

ARTICLE VII

ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION

(1) COMMISSION CREATED.—The member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

(a) The commission is an instrumentality of the member states.

(b) Venue is proper, and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) The compact may not be construed to be a waiver of sovereign immunity.

(2) MEMBERSHIP, VOTING, AND MEETINGS.—

(a) Each member state has and is limited to one delegate selected by that member state's physical therapy licensing board to serve on the commission. The delegate must be a current member of the physical therapy licensing board who is a physical therapist, a physical therapist assistant, a public member, or the board administrator.

(b) A delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring on the commission must be filled by the physical therapy licensing board of the member state for which the vacancy exists.

(c) Each delegate is entitled to one vote with regard to the adoption of rules and bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

(d) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(e) The commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws.

(f) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in article IX.

(g) The commission or the executive board or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive board or other committees of the commission must discuss any of the following:

1. Noncompliance of a member state with its obligations under the compact.

2. The employment, compensation, or discipline of, or other matters, practices, or procedures related to, specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation against the commission, executive board, or other committees of the commission.

4. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.

5. An accusation of any person of a crime or a formal censure of any person.

6. Information disclosing trade secrets or commercial or financial information that is privileged or confidential.

7. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.

8. Investigatory records compiled for law enforcement purposes.

9. Information related to any investigative reports prepared by or on behalf of or for use of the commission or

other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact.

10. Matters specifically exempted from disclosure by federal or member state statute.

(h) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(i) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action must be identified in the minutes. All minutes and documents of a closed meeting must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(3) DUTIES.—The commission shall do all of the following:

(a) Establish the fiscal year of the commission.

(b) Establish bylaws.

(c) Maintain its financial records in accordance with the bylaws.

(d) Meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(4) POWERS.—The commission may do any of the following:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules have the force and effect of law and are be binding in all member states.

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law is not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(e) Hire employees and elect or appoint officers; fix compensation of, define duties of, and grant appropriate authority to such individuals to carry out the purposes of the compact; and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(f) Accept any appropriate donations and grants of money, equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(g) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission

avoids any appearance of impropriety or conflict of interest.

(h) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(i) Establish a budget and make expenditures.

(j) Borrow money.

(k) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in the compact and the bylaws.

(l) Provide information to, receive information from, and cooperate with law enforcement agencies.

(m) Establish and elect an executive board.

(n) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of physical therapy licensure and practice.

(5) THE EXECUTIVE BOARD.—

(a) The executive board may act on behalf of the commission according to the terms of the compact.

(b) The executive board shall consist of the following nine members:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. One ex-officio, nonvoting member from the recognized national physical therapy professional association.

3. One ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

(c) The ex officio members shall be selected by their respective organizations.

(d) The commission may remove any member of the executive board as provided in its bylaws.

(e) The executive board shall meet at least annually.

(f) The executive board shall do all of the following:

1. Recommend to the entire commission changes to the rules or bylaws, compact legislation, fees paid by compact member states, such as annual dues, and any commission compact fee charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractually or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Perform other duties as provided in the rules or bylaws.

(6) FINANCING OF THE COMMISSION.—

(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The commission may accept any appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) The commission may levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based upon a formula to be determined by the commission, which shall adopt a rule binding upon all member states.

(d) The commission may not incur obligations of any kind before securing the funds adequate to meet such obligations; nor may the commission pledge the credit of any of the member states, except by and with the authority of the member state.

(e) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be

audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION.—

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, this paragraph may not be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection may not be construed to prohibit any

member, officer, executive director, employee, or representative of the commission from retaining his or her own counsel or to require the commission to defend such person if the actual or alleged act, error, or omission resulted from that person's intentional, willful, or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states.

(2) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to

the data system on all individuals to whom the compact is applicable as required by the rules of the commission, including all of the following:

(a) Identifying information.

(b) Licensure data.

(c) Investigative information.

(d) Adverse actions against a license or compact privilege.

(e) Nonconfidential information related to alternative program participation.

(f) Any denial of application for licensure and the reason for such denial.

(g) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Investigative information in the system pertaining to a licensee in any member state must be available only to other member states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license in a member state. Adverse action information pertaining to a licensee in any member state must be available to all other member states.

(5) Member states contributing information to the data system may designate information that may not be shared with the

public without the express permission of the contributing state.

(6) Any information submitted to the data system which is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE IX

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, such rule does not have further force and effect in any member state.

(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule or rules by the commission, and at least 30 days before the meeting at which the rule will be considered and voted upon, the commission must file a notice of proposed rulemaking on all of the following:

(a) The website of the commission or another publicly accessible platform.

(b) The website of each member state physical therapy licensing board or another publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed date, time, and location of the meeting in which the rule will be considered and voted upon.

(b) The text of the proposed rule or amendment and the reason for the proposed rule.

(c) A request for comments on the proposed rule from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before adoption of a proposed rule, the commission must allow persons to submit written data, facts, opinions, and arguments, which must be made available to the public.

(7) The commission must grant an opportunity for a public hearing before it adopts a rule or an amendment if a hearing is requested by any of the following:

(a) At least 25 persons.

(b) A state or federal governmental subdivision or agency.

(c) An association having at least 25 members.

(8) If a scheduled public hearing is held on the proposed

rule or amendment, the commission must publish the date, time, and location of the hearing. If the hearing is held through electronic means, the commission must publish the mechanism for access to the electronic hearing.

(a) All persons wishing to be heard at the hearing must notify the executive director of the commission or another designated member in writing of their desire to appear and testify at the hearing at least 5 business days before the scheduled date of the hearing.

(b) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(c) All hearings must be recorded. A copy of the recording must be made available on request.

(d) This section may not be construed to require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this section.

(9) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(10) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public

hearing.

(11) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this section are retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to do any of the following:

(a) Meet an imminent threat to public health, safety, or welfare.

(b) Prevent a loss of commission or member state funds.

(c) Meet a deadline for the adoption of an administrative rule established by federal law or rule.

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of

the commission. The revision is subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the commission before the end of the notice period. If a challenge is not made, the revision takes effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE X

OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

(1) OVERSIGHT.—

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and take all actions necessary and appropriate to carry out the compact's purposes and intent. The provisions of the compact and the rules adopted pursuant thereto shall have standing as statutory law.

(b) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities, or actions of the commission.

(c) The commission is entitled to receive service of

process in any such proceeding and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission renders a judgment or an order void as to the commission, the compact, or the adopted rules.

(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION.—

(a) If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or the adopted rules, the commission must do all of the following:

1. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, and any other action to be taken by the commission.

2. Provide remedial training and specific technical assistance regarding the default.

(b) If a state in default fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states, and all rights, privileges, and benefits conferred by the compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(c) Termination of membership in the compact may be imposed only after all other means of securing compliance have been exhausted. The commission shall give notice of intent to

suspend or terminate a defaulting member state to the governor and majority and minority leaders of the defaulting state's legislature and to each of the member states.

(d) A state that has been terminated from the compact is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(e) The commission does not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting state.

(f) The defaulting state may appeal the action of the commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(3) DISPUTE RESOLUTION.—

(a) Upon request by a member state, the commission must attempt to resolve disputes related to the compact which arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(4) ENFORCEMENT.—

(a) The commission, in the reasonable exercise of its discretion, shall enforce the compact and the commission's rules.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) The remedies under this article are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XI

DATE OF IMPLEMENTATION OF THE PHYSICAL THERAPY COMPACT AND ASSOCIATED RULES; WITHDRAWAL; AND AMENDMENTS

(1) The compact becomes effective on the date that the compact statute is enacted into law in the tenth member state. The provisions that become effective at that time are limited to the powers granted to the commission relating to assembly and the adoption of rules. Thereafter, the commission shall meet and

exercise rulemaking powers necessary for the implementation and administration of the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date that the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) Any member state may withdraw from the compact by enacting a statute repealing the same.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act before the effective date of withdrawal.

(4) The compact may not be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state which does not conflict with the provisions of the compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding upon any member state until it is enacted into the laws of all

member states.

ARTICLE XII

CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to carry out the purposes thereof. The provisions of the compact are severable, and if any phrase, clause, sentence, or provision of the compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If the compact is held contrary to the constitution of any member state, the compact remains in full force and effect as to the remaining member states and in full force and effect as to the member state affected as to all severable matters.

Section 80. The provisions of the Physical Therapy Licensure Compact do not authorize the Department of Health or the Board of Physical Therapy to collect a compact privilege fee, but rather state that fees of this kind are allowable under the compact. The Department of Health and the Board of Physical Therapy must comply with the requirements of s. 456.025.

Section 81. Subsection (5) is added to section 486.023, Florida Statutes, to read:

486.023 Board of Physical Therapy Practice.—

(5) The board shall appoint a person to serve as the state's delegate on the Physical Therapy Compact Commission, as required under s. 486.112.

Section 82. Section 486.125, Florida Statutes, is amended to read:

486.125 Refusal, revocation, or suspension of license; administrative fines and other disciplinary measures.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2) or s. 486.112:

(a) Being unable to practice physical therapy with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition.

1. In enforcing this paragraph, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the licensee is unable to practice physical therapy due to the reasons stated in this paragraph, the department shall have the authority to compel a physical therapist or physical therapist assistant to submit to a mental or physical examination by a physician designated by the department. If the licensee refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement

in the circuit court where the licensee resides or serves as a physical therapy practitioner. The licensee against whom the petition is filed may ~~shall~~ not be named or identified by initials in any public court records or documents, and the proceedings must ~~shall~~ be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011.

2. A physical therapist or physical therapist assistant whose license is suspended or revoked pursuant to this subsection shall, at reasonable intervals, be given an opportunity to demonstrate that she or he can resume the competent practice of physical therapy with reasonable skill and safety to patients.

3. Neither the record of proceeding nor the orders entered by the board in any proceeding under this subsection may be used against a physical therapist or physical therapist assistant in any other proceeding.

(b) Having committed fraud in the practice of physical therapy or deceit in obtaining a license as a physical therapist or as a physical therapist assistant.

(c) Being convicted or found guilty regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of physical therapy or to the ability to practice physical therapy. The entry of any plea of nolo contendere is ~~shall be~~ considered a conviction for purpose of

this chapter.

(d) Having treated or undertaken to treat human ailments by means other than by physical therapy, as defined in this chapter.

(e) Failing to maintain acceptable standards of physical therapy practice as set forth by the board in rules adopted pursuant to this chapter.

(f) Engaging directly or indirectly in the dividing, transferring, assigning, rebating, or refunding of fees received for professional services, or having been found to profit by means of a credit or other valuable consideration, such as an unearned commission, discount, or gratuity, with any person referring a patient or with any relative or business associate of the referring person. ~~Nothing in~~ This chapter may not ~~shall~~ be construed to prohibit the members of any regularly and properly organized business entity which is comprised of physical therapists and which is recognized under the laws of this state from making any division of their total fees among themselves as they determine necessary.

(g) Having a license revoked or suspended; having had other disciplinary action taken against her or him; or having had her or his application for a license refused, revoked, or suspended by the licensing authority of another state, territory, or country.

(h) Violating a lawful order of the board or department

previously entered in a disciplinary hearing.

(i) Making or filing a report or record which the licensee knows to be false. Such reports or records shall include only those which are signed in the capacity of a physical therapist.

(j) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which the licensee knows or has reason to know that she or he is not competent to perform, including, but not limited to, specific spinal manipulation.

(k) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

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

(b) The board may take adverse action against a physical therapist's or a physical therapist assistant's compact privilege under the Physical Therapy Licensure Compact pursuant to s. 486.112, and may impose any of the penalties in s. 456.072(2), if a physical therapist or physical therapist assistant commits an act specified in subsection (1) or s. 456.072(1).

(3) The board may ~~shall~~ not reinstate the license of a physical therapist or physical therapist assistant or approve

~~cause~~ a license to be issued to a person it has deemed unqualified until such time as it is satisfied that she or he has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of physical therapy.

Section 83. Paragraph (b) of subsection (1) of section 624.27, Florida Statutes, is amended to read:

624.27 Direct health care agreements; exemption from code.—

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

(b) "Health care provider" means a health care provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 464, ~~or~~ chapter 466, chapter 490, or chapter 491, or a health care group practice, who provides health care services to patients.

Section 84. Subsections (4) through (12) of section 95.11, Florida Statutes, are renumbered as subsections (5) through (13), respectively, paragraph (b) of subsection (2), paragraph (n) of subsection (3), paragraphs (f) and (g) of present subsection (5), and present subsection (10) are amended, and a new subsection (4) is added to that section, to read:

95.11 Limitations other than for the recovery of real property.—Actions other than for recovery of real property shall be commenced as follows:

(2) WITHIN FIVE YEARS.—

(b) A legal or equitable action on a contract, obligation, or liability founded on a written instrument, except for an action to enforce a claim against a payment bond, which shall be governed by the applicable provisions of paragraph (6)(e) ~~paragraph (5)(e)~~, s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by paragraph (6)(h) ~~paragraph (5)(h)~~.

(3) WITHIN FOUR YEARS.—

(n) An action for assault, battery, false arrest, malicious prosecution, malicious interference, false imprisonment, or any other intentional tort, except as provided in subsections (5), (6), and (8) ~~subsections (4), (5), and (7)~~.

(4) WITHIN THREE YEARS.—An action to collect medical debt for services rendered by a facility licensed under chapter 395, provided that the period of limitations shall run from the date on which the facility refers the medical debt to a third party for collection.

(6)~~(5)~~ WITHIN ONE YEAR.—

(f) Except for actions described in subsection (9)~~(8)~~, a petition for extraordinary writ, other than a petition challenging a criminal conviction, filed by or on behalf of a prisoner as defined in s. 57.085.

(g) Except for actions described in subsection (9)~~(8)~~, an action brought by or on behalf of a prisoner, as defined in s. 57.085, relating to the conditions of the prisoner's

confinement.

(11) ~~(10)~~ FOR INTENTIONAL TORTS RESULTING IN DEATH FROM ACTS DESCRIBED IN S. 782.04 OR S. 782.07.—Notwithstanding paragraph (5)(e) ~~paragraph (4)(e)~~, an action for wrongful death seeking damages authorized under s. 768.21 brought against a natural person for an intentional tort resulting in death from acts described in s. 782.04 or s. 782.07 may be commenced at any time. This subsection shall not be construed to require an arrest, the filing of formal criminal charges, or a conviction for a violation of s. 782.04 or s. 782.07 as a condition for filing a civil action.

Section 85. Section 222.26, Florida Statutes, is created to read:

222.26 Additional exemptions from legal process concerning medical debt.—If a debt is owed for medical services provided by a facility licensed under chapter 395, the following property is exempt from attachment, garnishment, or other legal process in an action on such debt:

(1) A debtor's interest, not to exceed $10,000 in value, in a single motor vehicle as defined in s. 320.01(1).

(2) A debtor's interest in personal property, not to exceed $10,000 in value, if the debtor does not claim or receive the benefits of a homestead exemption under s. 4, Art. X of the State Constitution.

Section 86. Section 627.446, Florida Statutes, is created

to read:

627.446 Advanced explanation of benefits.—

(1) As used in this section, the term "health insurer" means a health insurer issuing individual or group coverage or a health maintenance organization issuing coverage through an individual or a group contract.

(2) Each health insurer shall prepare an advanced explanation of benefits upon receiving a patient estimate from a facility pursuant to s. 395.301(1). The health insurer must provide the advanced explanation of benefits to the insured no later than 1 business day after receiving the patient estimate from the facility or, in the case of a service scheduled at least 10 business days in advance, no later than 3 business days after receiving such estimate.

(3) At a minimum, the advanced explanation of benefits must include detailed coverage and cost-sharing information pursuant to the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260.

Section 87. Section 627.447, Florida Statutes, is created to read:

627.447 Disclosure of discounted cash prices.—A health insurer may not prohibit a provider from disclosing to an insured the option to pay the provider's discounted cash price for health care services. For purposes of this section, the term "discounted cash price" means:

(1) With respect to a hospital facility, the same meaning as in 45 CFR 180.20. The term does not include the amount charged to an individual pursuant to a facility's financial assistance policy.

(2) With respect to a provider that is not a hospital, the charge that is applied to an individual who paid for a health care service without filing an insurance claim.

Section 88. Paragraphs (b) and (c) of subsection (2), subsection (3), and paragraph (a) of subsection (4) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

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

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 627.446 ~~s. 624.603~~.

(c) "Shared savings incentive" means a voluntary and optional financial incentive that a health insurer provides ~~may provide~~ to an insured for choosing certain shoppable health care services under a shared savings incentive program which ~~and~~ may include, but is not limited to, the incentives described in s. 626.9541(4)(a).

(3) A health insurer must ~~may~~ offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health

insurer ~~that offers a shared savings incentive program~~ must:

(a) Establish the program as a component part of the policy or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the availability of the shared savings incentive program, ~~and~~ the procedure to participate in the program, and that participation by the insured is voluntary and optional.

(d) Publish on a web page easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of insureds who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health insurer.

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical

expense for such purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

Section 89. Paragraph (a) of subsection (4) of section 627.6648, Florida Statutes, is amended to read:

627.6648 Shared savings incentive program.—

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical expense for such purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

Section 90. Paragraph (a) of subsection (4) of section 641.31076, Florida Statutes, is amended to read:

641.31076 Shared savings incentive program.—

(4) A shared savings incentive offered by a health maintenance organization in accordance with this section:

(a) Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical expense for such purposes.

Section 91. Paragraph (e) of subsection (3) of section 766.1115, Florida Statutes, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

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

(e) "Low-income" means:

1. A person who is Medicaid-eligible under Florida law;

2. A person who is without health insurance and whose family income does not exceed 300 ~~200~~ percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or

3. Any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.

Section 92. Subsection (14) of section 768.28, Florida Statutes, is amended, and paragraphs (j), (k), and (l) are added to subsection (10) of that section, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(10)

(j) For purposes of this section, the representatives appointed from the Board of Medicine and the Board of Osteopathic Medicine, when serving as commissioners of the

Interstate Medical Licensure Compact Commission pursuant to s. 456.4501, and any administrator, officer, executive director, employee, or representative of the Interstate Medical Licensure Compact Commission, when acting within the scope of their employment, duties, or responsibilities in this state, are considered agents of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

(k) For purposes of this section, the individuals appointed under s. 468.1135(4) as the state's delegates on the Audiology and Speech-Language Pathology Interstate Compact Commission, when serving in that capacity under s. 468.1335, and any administrator, officer, executive director, employee, or representative of the commission, when acting within the scope of his or her employment, duties, or responsibilities in the state, is considered an agent of the state. The commission shall pay any claims or judgments under this section and may maintain insurance coverage to pay any such claims or judgments.

(l) For purposes of this section, the individual appointed under s. 486.023(5) as the state's delegate on the Physical Therapy Compact Commission, when serving in that capacity under s. 486.112, and any administrator, officer, executive director, employee, or representative of the Physical Therapy Compact Commission, when acting within the scope of his or her employment, duties, or responsibilities in this state, is

considered an agent of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

(14) Every claim against the state or one of its agencies or subdivisions for damages for a negligent or wrongful act or omission pursuant to this section shall be forever barred unless the civil action is commenced by filing a complaint in the court of appropriate jurisdiction within 4 years after such claim accrues; except that an action for contribution must be commenced within the limitations provided in s. 768.31(4), and an action for damages arising from medical malpractice or wrongful death must be commenced within the limitations for such actions in s. 95.11(5) ~~s. 95.11(4)~~.

Section 93. Paragraph (f) is added to subsection (3) of section 1002.32, Florida Statutes, to read:

1002.32 Developmental research (laboratory) schools.—

(3) MISSION.—The mission of a lab school shall be the provision of a vehicle for the conduct of research, demonstration, and evaluation regarding management, teaching, and learning. Programs to achieve the mission of a lab school shall embody the goals and standards established pursuant to ss. 1000.03(5) and 1001.23(1) and shall ensure an appropriate education for its students.

(f) Each lab school shall develop programs that accelerate the entry of students into articulated health care programs at

its affiliated university or at any public or private postsecondary institution, with the approval of the university president. Each lab school shall offer technical assistance to any school district seeking to replicate the lab school's programs and must annually report to the President of the Senate and the Speaker of the House of Representatives on the development and results of such programs, when available.

Section 94. Paragraph (c) is added to subsection (6) of section 1004.015, Florida Statutes, to read:

1004.015 Florida Talent Development Council.—

(6) The council shall coordinate, facilitate, and communicate statewide efforts to meet supply and demand needs for the state's health care workforce. Annually, by December 1, the council shall report on the implementation of this subsection and any other relevant information on the Florida Talent Development Council's web page located on the Department of Economic Opportunity's website. To support the efforts of the council, the Board of Governors and the State Board of Education shall:

(c) Require the Commission for Independent Education and the Independent Colleges and Universities of Florida to annually report, for each medical school graduate, by institution and program, the graduates' accepted postgraduation residency programs, including location and specialty. For graduates who accepted a residency program in this state, reported data shall

identify the accredited program and sponsoring institution of the residency program.

Section 95. Paragraph (b) of subsection (3) and paragraph (b) of subsection (9) of section 1009.8962, Florida Statutes, are amended to read:

1009.8962 Linking Industry to Nursing Education (LINE) Fund.—

(3) As used in this section, the term:

(b) "Institution" means a school district career center under s. 1001.44;~~,~~ a charter technical career center under s. 1002.34;~~,~~ a Florida College System institution;~~,~~ a state university;~~, or~~ an independent nonprofit college or university located and chartered in this state and accredited by an agency or association that is recognized by the database created and maintained by the United States Department of Education to grant baccalaureate degrees; or an independent school, college, or university with an accredited nursing education program as defined in s. 464.003 which is located in and chartered by the state and is licensed by the Commission for Independent Education pursuant to s. 1005.31, which has a nursing education program that meets or exceeds the following:

1. For a certified nursing assistant program, a completion rate of at least 70 percent for the prior year.

2. For a licensed practical nurse, associate of science in nursing, and bachelor of science in nursing program, a first-

time passage rate on the National Council of State Boards of Nursing Licensing Examination of at least 75 ~~70~~ percent for the prior year based on at least 10 testing participants.

(9)

(b) Annually, by February 1, ~~each institution awarded grant funds in the previous fiscal year shall submit a report to~~ the Board of Governors and the ~~or~~ Department of Education shall submit to the Governor, President of the Senate, and Speaker of the House of Representatives a report~~, as applicable,~~ that demonstrates the expansion as outlined in each ~~the~~ proposal and the use of funds. At minimum, the report must include, by program level, the number of additional nursing education students enrolled; if scholarships were awarded using grant funds, the number of students who received scholarships and the average award amount; and the outcomes of students as reported by the Florida Talent Development Council pursuant to s. 1004.015(6).

Section 96. Section 486.025, Florida Statutes, is amended to read:

486.025 Powers and duties of the Board of Physical Therapy Practice.—The board may administer oaths, summon witnesses, take testimony in all matters relating to its duties under this chapter, establish or modify minimum standards of practice of physical therapy as defined in s. 486.021, including, but not limited to, standards of practice for the performance of dry

needling by physical therapists, and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this chapter. The board may also review the standing and reputability of any school or college offering courses in physical therapy and whether the courses of such school or college in physical therapy meet the standards established by the appropriate accrediting agency referred to in s. 486.031(1)(c) ~~s. 486.031(3)(a)~~. In determining the standing and reputability of any such school and whether the school and courses meet such standards, the board may investigate and personally inspect the school and courses.

Section 97. Paragraph (b) of subsection (1) of section 486.0715, Florida Statutes, is amended to read:

486.0715 Physical therapist; issuance of temporary permit.—

(1) The board shall issue a temporary physical therapist permit to an applicant who meets the following requirements:

(b) Is a graduate of an approved United States physical therapy educational program and meets all the eligibility requirements for licensure under ch. 456, s. 486.031(1)(a), (b), and (c)1. ~~s. 486.031(1)-(3)(a)~~, and related rules, except passage of a national examination approved by the board is not required.

Section 98. Paragraph (b) of subsection (1) of section 486.1065, Florida Statutes, is amended to read:

486.1065 Physical therapist assistant; issuance of

temporary permit.—

(1) The board shall issue a temporary physical therapist assistant permit to an applicant who meets the following requirements:

(b) Is a graduate of an approved United States physical therapy assistant educational program and meets all the eligibility requirements for licensure under ch. 456, s. 486.102(1)(a), (b), and (c)1. ~~s. 486.102(1)-(3)(a)~~, and related rules, except passage of a national examination approved by the board is not required.

Section 99. Subsection (3) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(3) USE OF FUNDS.—It is the intent of the Legislature that funds as appropriated shall be utilized by the department for the purpose of increasing the number of primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses in rural areas, either through the Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program established in s. 381.402 ~~as defined by s. 1009.65~~ or through a federal loan repayment program which requires state matching funds. The department may use funds appropriated for the Florida Reimbursement Assistance for Medical Education ~~Reimbursement and Loan Repayment~~ Program as matching funds for federal loan

repayment programs for health care personnel, such as that authorized in Pub. L. No. 100-177, s. 203. If the department receives federal matching funds, the department shall only implement the federal program. Reimbursement through either program shall be limited to:

(a) Primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural hospitals, as defined in this act; and

(b) Primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural area health education centers, as defined in this section. These personnel shall practice:

1. In a county with a population density of no greater than 100 persons per square mile; or

2. Within the boundaries of a hospital tax district which encompasses a population of no greater than 100 persons per square mile.

If the department administers a federal loan repayment program, priority shall be given to obligating state and federal matching funds pursuant to paragraphs (a) and (b). The department may use federal matching funds in other health workforce shortage areas and medically underserved areas in the state for loan repayment

programs for primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses who are employed by publicly financed health care programs that serve medically indigent persons.

Section 100. Subsection (1) of section 458.316, Florida Statutes, is amended to read:

458.316 Public health certificate.—

(1) Any person desiring to obtain a public health certificate shall submit an application fee not to exceed $300 and shall demonstrate to the board that he or she is a graduate of an accredited medical school and holds a master of public health degree or is board eligible or certified in public health or preventive medicine, or is licensed to practice medicine without restriction in another jurisdiction in the United States and holds a master of public health degree or is board eligible or certified in public health or preventive medicine, and shall meet the requirements in s. 458.311(1)(a)-(g) and (6) ~~(5)~~.

Section 101. Section 458.3165, Florida Statutes, is amended to read:

458.3165 Public psychiatry certificate.—The board shall issue a public psychiatry certificate to an individual who remits an application fee not to exceed $300, as set by the board, who is a board-certified psychiatrist, who is licensed to practice medicine without restriction in another state, and who meets the requirements in s. 458.311(1)(a)-(g) and (6) ~~(5)~~. A

recipient of a public psychiatry certificate may use the certificate to work at any public mental health facility or program funded in part or entirely by state funds.

(1) Such certificate shall:

(a) Authorize the holder to practice only in a public mental health facility or program funded in part or entirely by state funds.

(b) Be issued and renewable biennially if the State Surgeon General and the chair of the department of psychiatry at one of the public medical schools or the chair of the department of psychiatry at the accredited medical school at the University of Miami recommend in writing that the certificate be issued or renewed.

(c) Automatically expire if the holder's relationship with a public mental health facility or program expires.

(d) Not be issued to a person who has been adjudged unqualified or guilty of any of the prohibited acts in this chapter.

(2) The board may take disciplinary action against a certificateholder for noncompliance with any part of this section or for any reason for which a regular licensee may be subject to discipline.

Section 102. Subsection (3) of section 468.209, Florida Statutes, is amended to read:

468.209 Requirements for licensure.—

(3) If the board determines that an applicant is qualified to be licensed by endorsement under s. 456.0145 ~~s. 468.213~~, the board may issue the applicant a temporary permit to practice occupational therapy until the next board meeting at which license applications are to be considered, but not for a longer period of time. Only one temporary permit by endorsement shall be issued to an applicant, and it shall not be renewable.

Section 103. Subsection (5) of section 468.511, Florida Statutes, is amended to read:

468.511 Dietitian/nutritionist; temporary permit.—

~~(5) If the board determines that an applicant is qualified to be licensed by endorsement under s. 468.513, the board may issue the applicant a temporary permit to practice dietetics and nutrition until the next board meeting at which license applications are to be considered, but not for a longer period of time.~~

Section 104. Paragraphs (a) and (j) of subsection (1) of section 475.01, Florida Statutes, are amended to read:

475.01 Definitions.—

(1) As used in this part:

(a) "Broker" means a person who, for another, and for a compensation or valuable consideration directly or indirectly paid or promised, expressly or impliedly, or with an intent to collect or receive a compensation or valuable consideration therefor, appraises, auctions, sells, exchanges, buys, rents, or

offers, attempts or agrees to appraise, auction, or negotiate the sale, exchange, purchase, or rental of business enterprises or business opportunities or any real property or any interest in or concerning the same, including mineral rights or leases, or who advertises or holds out to the public by any oral or printed solicitation or representation that she or he is engaged in the business of appraising, auctioning, buying, selling, exchanging, leasing, or renting business enterprises or business opportunities or real property of others or interests therein, including mineral rights, or who takes any part in the procuring of sellers, purchasers, lessors, or lessees of business enterprises or business opportunities or the real property of another, or leases, or interest therein, including mineral rights, or who directs or assists in the procuring of prospects or in the negotiation or closing of any transaction which does, or is calculated to, result in a sale, exchange, or leasing thereof, and who receives, expects, or is promised any compensation or valuable consideration, directly or indirectly therefor; and all persons who advertise rental property information or lists. A broker renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~. Where the term "appraise" or "appraising" appears in the definition of the term "broker," it specifically excludes those appraisal services which must be performed only by a state-licensed or state-certified appraiser, and those appraisal

services which may be performed by a registered trainee appraiser as defined in part II. The term "broker" also includes any person who is a general partner, officer, or director of a partnership or corporation which acts as a broker. The term "broker" also includes any person or entity who undertakes to list or sell one or more timeshare periods per year in one or more timeshare plans on behalf of any number of persons, except as provided in ss. 475.011 and 721.20.

(j) "Sales associate" means a person who performs any act specified in the definition of "broker," but who performs such act under the direction, control, or management of another person. A sales associate renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~.

Section 105. Paragraph (h) of subsection (1) of section 475.611, Florida Statutes, is amended to read:

475.611 Definitions.—

(1) As used in this part, the term:

(h) "Appraiser" means any person who is a registered trainee real estate appraiser, a licensed real estate appraiser, or a certified real estate appraiser. An appraiser renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~.

Section 106. Subsection (7) of section 517.191, Florida Statutes, is amended to read:

517.191 Injunction to restrain violations; civil penalties; enforcement by Attorney General.—

(7) Notwithstanding s. 95.11(5)(f) ~~s. 95.11(4)(f)~~, an enforcement action brought under this section based on a violation of any provision of this chapter or any rule or order issued under this chapter shall be brought within 6 years after the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence, but not more than 8 years after the date such violation occurred.

Section 107. Subsection (4) of section 787.061, Florida Statutes, is amended to read:

787.061 Civil actions by victims of human trafficking.—

(4) STATUTE OF LIMITATIONS.—The statute of limitations as specified in s. 95.11(8) or (10) ~~s. 95.11(7) or (9)~~, as applicable, governs an action brought under this section.

Section 108. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $25,000,000 in nonrecurring funds from the General Revenue Fund is appropriated in the Grants and Aids - Health Care Education Reimbursement and Loan Repayment Program category to the Department of Health for the Florida Reimbursement Assistance for Medical Education Program established in s. 381.402, Florida Statutes.

Section 109. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $8,000,000 in nonrecurring funds from

the General Revenue Fund is appropriated in the Dental Student Loan Repayment Program category to the Department of Health for the Dental Student Loan Repayment Program established in s. 381.4019, Florida Statutes.

Section 110. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $23,357,876 in recurring funds from the General Revenue Fund is appropriated in the Grants and Aids - Minority Health Initiatives category to the Department of Health to expand statewide the telehealth minority maternity care program established in s. 383.2163, Florida Statutes. The department shall establish 15 regions in which to implement the program statewide based on the location of hospitals providing obstetrics and maternity care and pertinent data from nearby counties for severe maternal morbidity and maternal mortality. The department shall identify the criteria for selecting providers for regional implementation and, at a minimum, consider the maternal level of care designations for hospitals within the region, the neonatal intensive care unit levels of hospitals within the region, and the experience of community-based organizations to screen for and treat common pregnancy-related complications.

Section 111. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $15,000,000 in recurring funds from the General Revenue Fund is appropriated to the Agency for Health Care Administration to implement the Training, Education, and

Clinicals in Health (TEACH) Funding Program established in s. 409.91256, Florida Statutes, as created by this act.

Section 112. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $2,000,000 in recurring funds from the General Revenue Fund is appropriated to the University of Florida, Florida State University, Florida Atlantic University, and Florida Agricultural and Mechanical University for the purpose of implementing lab school-articulated health care programs required by s. 1002.32, Florida Statutes. Each state university shall receive $500,000 from this appropriation.

Section 113. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $5,000,000 in recurring funds from the General Revenue Fund is appropriated in the Aid to Local Governments Grants and Aids - Nursing Education category to the Department of Education for the purpose of implementing the Linking Industry to Nursing Education (LINE) Fund established in s. 1009.8962, Florida Statutes.

Section 114. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $14,920,500 in recurring funds from the General Revenue Fund and $20,079,500 in recurring funds from the Medical Care Trust Fund are appropriated in the Graduate Medical Education category to the Agency for Health Care Administration for the Slots for Doctors Program established in s. 409.909, Florida Statutes.

Section 115. Effective July 1, 2024, for the 2024-2025

fiscal year, the sums of $42,630,000 in recurring funds from the Grants and Donations Trust Fund and $57,370,000 in recurring funds from the Medical Care Trust Fund are appropriated in the Graduate Medical Education category to the Agency for Health Care Administration to provide to statutory teaching hospitals as defined in s. 408.07(46), Florida Statutes, which provide highly specialized tertiary care, including comprehensive stroke and Level 2 adult cardiovascular services; NICU II and III; and adult open heart; and which have more than 30 full-time equivalent (FTE) residents over the Medicare cap in accordance with the CMS-2552 provider 2021 fiscal year-end federal Centers for Medicare and Medicaid Services Healthcare Cost Report, HCRIS data extract on December 1, 2022, worksheet E-4, line 6 minus worksheet E-4, line 5, shall be designated as a High Tertiary Statutory Teaching Hospital and be eligible for funding calculated on a per Graduate Medical Education resident-FTE proportional allocation that shall be in addition to any other Graduate Medical Education funding. Of these funds, $44,562,400 shall be first distributed to hospitals with greater than 500 unweighted fiscal year 2022-2023 FTEs. The remaining funds shall be distributed proportionally based on the total unweighted fiscal year 2022-2023 FTEs. Payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the

Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section.

Section 116. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $32,464,472 in recurring funds from the General Revenue Fund and $43,689,578 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping (DRG) reimbursement methodology and increase the existing marginal cost percentages for transplant pediatrics, pediatrics, and neonates.

Section 117. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $14,888,903 in recurring funds from the General Revenue Fund and $20,036,979 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for preventative dental care services. The funding shall be held in reserve. The agency shall develop a plan to increase Medicaid reimbursement rates for preventative dental care services by September 1, 2024. The agency may submit a budget amendment pursuant to chapter 216, Florida Statutes, requesting release of the funding. The budget amendment must include the final plan to increase Medicaid reimbursement rates for preventative dental care services. Health plans that participate in the Statewide Medicaid Managed Care program shall

pass through the fee increase to providers in this appropriation.

Section 118. Effective July 1, 2024, for or the 2024-2025 fiscal year, the sums of $29,209,696 in recurring funds from the General Revenue Fund and $39,309,413 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community Based Services Waiver category to the Agency for Persons with Disabilities to provide a uniform iBudget Waiver provider rate increase. The sum of $68,519,109 in recurring funds from the Medical Care Trust Fund is appropriated in the Home and Community Based Services Waiver category to the Agency for Health Care Administration to establish budget authority for Medicaid services.

Section 119. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $11,525,152 in recurring funds from the General Revenue Fund is appropriated in the Grants and Aids - Community Mental Health Services category to the Department of Children and Families to enhance crisis diversion through mobile response teams established under s. 394.495, Florida Statutes, by adding an additional 16 mobile response teams to ensure coverage in every county.

Section 120. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $1,000,000 in recurring funds from the General Revenue Fund is appropriated to the Department of Health to implement the Health Care Screening and Services Grant

Program established in s. 381.9855, Florida Statutes, as created by this act.

Section 121. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $150,000 in nonrecurring funds from the General Revenue Fund and $150,000 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers. The agency shall submit the reimbursement methodology and estimated fiscal impact to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Appropriations Committee, and the chair of the House Appropriations Committee no later than December 31, 2024.

Section 122. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $12,365,771 in recurring funds from the General Revenue Fund, $127,300 in recurring funds from the Refugee Assistance Trust Fund, and $16,514,132 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 123. Effective October 1, 2024, for the 2024-2025

fiscal year, the sums of $14,580,660 in recurring funds from the General Revenue Fund and $19,622,154 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 124. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $9,666,352 in recurring funds from the General Revenue Fund and $13,008,646 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 125. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

PCB SHI 24-01

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: Pub. Rec. & Meetings PCB SHI 24-01 Public Records and Meetings Exemptions
SPONSOR(S): Select Committee on Health Innovation
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Select Committee on Health Innovation		McElroy	Calamas

SUMMARY ANALYSIS

The bill requires Florida to join the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact and the Physical Therapy Licensure Compact.

Each of these compacts requires compact member states to share certain licensure and personal identifying information for physicians, speech-language pathologists, audiologists, and physical therapists authorized to practice under their respective compact.

The bill creates a public records exemption for certain licensure and personal identifying information, other than the name, licensure information, or licensure number, for providers authorized to practice under each compact, obtained from the data system and held by the Department of Health or the applicable board from public records requirements, unless the laws of the state that originally reported the information authorizes disclosure.

The bill allows the Commission of each compact to convene in a closed meeting if the meeting is held to discuss certain specified matters. The bill also creates a public meeting exemption for Commission meetings in which a matter discussed is specifically exempted from disclosure by federal or state law. The bill provides that any recordings, minutes, and records generated from such a meeting, or portions of such meeting, are also exempt from public records requirements.

The bill provides that the public records and public meeting exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless saved from repeal by reenactment by the Legislature.

This bill will have a significant, negative fiscal impact on the Department of Health and no fiscal impact on local governments.

The bill will become effective on the same date that HB 1549 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill creates a public record exemption; thus, it requires a two-thirds vote for final passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Public Records Law

Article I, section 24(a) of the Florida Constitution sets forth the state's public policy regarding access to government records. This section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government.[1] The Legislature, however, may provide by general law for exemption from public record requirements provided the exemption passes by two-thirds vote of each chamber, states with specificity the public necessity justifying the exemption, and is no broader than necessary to meet its public purpose.[2]

The Florida Statutes also address the public policy regarding access to government records. Section 119.07(1), F.S., guarantees every person a right to inspect and copy any state, county, or municipal record, unless the record is exempt.[3] Furthermore, the Open Government Sunset Review Act[4] provides that a public record exemption may be created or maintained only if it serves an identifiable public purpose and the "Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption."[5] An identifiable public purpose is served if the exemption meets one of the following purposes:

- Allow the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protect sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety; however, only an individual maybe exempted under this provision; or
- Protect trade or business secrets.[6]

Pursuant to the Open Government Sunset Review Act, a new public record exemption or substantial amendment of an existing public record exemption is repealed on October 2nd of the fifth year following enactment, unless the Legislature reenacts the exemption.

Public Meetings Law

Article I, s. 24(b) of the State Constitution sets forth the state's public policy regarding access to government meetings. The section requires that all meetings of any collegial public body of the executive branch of state government or of any collegial public body of a county, municipality, school district, or special district, at which official acts are to be taken or at which public business of such body is to be transacted or discussed, be open and noticed to the public.

Public policy regarding access to government meetings also is addressed in the Florida Statutes. Section 286.011, F.S., known as the "Government in the Sunshine Law" or "Sunshine Law," further requires that all meetings of any board or commission of any state agency or authority or of any agency or authority of any county, municipal corporation, or political subdivision, at which official acts are to be taken be open to the public at all times.[7] The board or commission must provide reasonable notice of

[1] Art. I, s. 24(a), FLA. CONST.
[2] Art. I, s. 24(c), FLA. CONST.
[3] A public record exemption means a provision of general law which provides that a specified record, or portion thereof, is not subject to the access requirements of s. 119.07(1), F.S., or s. 24, Art. I of the State Constitution. *See* s. 119.011(8), F.S.
[4] Section 119.15, F.S.
[5] Section 119.15(6)(b), F.S.
[6] *Id.*
[7] Section 286.011(1), F.S.

all public meetings.[8] Public meetings may not be held at any location that discriminates on the basis of sex, age, race, creed, color, origin or economic status or which operates in a manner that unreasonably restricts the public's access to the facility.[9] Minutes of a public meeting must be promptly recorded and open to public inspection.[10]

Health Care Licensure Compacts

The bill requires Florida to join the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact and the Physical Therapy Licensure Compact. The compacts were created to facilitate multistate practice of licensed physicians, speech-language pathologists, audiologists, and physical therapists.

Under their respective compact, an eligible licensed physician, speech-language pathologist, audiologist, physical therapist or a physical therapist assistant is authorized to practice within the scope of his or her license in all compact member states. Each health care provider practicing under compact privilege must comply with the practice laws of the state in which he or she is providing service or where the patient is located.

Under each compact, member states are also required to report certain licensure information on all licensees in compact member states to a shared data system, including identifying information, licensure data, and any adverse actions taken against the health care providers license or compact privilege. Investigative information pertaining to a licensee in any compact member state must be available to other member states. Compact member states may designate information submitted to the data system that may not be shared with the public without the express permission of that member state.

Under each compact, Florida will be sharing information that is not currently exempt from disclosure requirements under s. 119.07(1), F.S. and s. 24(a), Art. 1 of the Florida Constitution.

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (Medical Compact) requires states to share licensee information for all licensed physicians, or physicians who have applied for licensure, to a coordinated data system. Information that will shared that is not currently exempt from disclosure under s. 119.07(1), F.S. and s. 24(a), Art. 1 of the Florida Constitution, includes:

- Identifying information;
- Licensure data;
- Public action taken against a licensed physician who has applied for or received an expedited license through the compact; and
- Public and confidential complaint, disciplinary, or investigatory information.

Audiology and Speech-Language Pathology Compact

The Audiology and Speech-Language Pathology Compact (ASLP Compact) requires member states to report the following licensure information and other non-exempt information for all licensed audiologists and speech-language pathologists practicing under the ASLP Compact:

- Identifying information;
- Licensure data;
- Adverse actions against the audiologist's or speech-language pathologist's license;
- Nonconfidential information related to participation in alternative programs;
- Any licensure application denials and reasons for such denial; and

[8] Id.
[9] Section 286.011(6), F.S.
[10] Section 286.011(2), F.S.

- Other information, determined by Commission rule, which may facilitate the administration of the compact.

Physical Therapy Licensure Compact

The Physical Therapy Licensure Compact (PT Compact) requires each member state to report the following licensure information and other non-exempt information for all licensed physical therapists and physical therapist assistants practicing under the compact:

- Identifying information;
- Licensure data;
- Investigative information;
- Adverse actions against the physical therapists or physical therapist assistant's license or compact privilege;
- Any licensure application denials and reasons for such denial; and
- Other information, determined by Commission rule, which may facilitate the administration of the compact.

Commission Meetings

The Medical Compact, ASLP Compact, and the PT Compact each require their respective compact Commission to conduct meetings. The Commission meetings must be open to the public and public notice must be given. However, for the discussion of certain specified topics, each compact requires the Commission to conduct a closed meeting. To conduct closed meetings in Florida, a specific exemption from the public meeting requirements under s. 24, Art. I of the State Constitution and s. 286.011, F.S. is needed. Current law does not provide a public meeting exemption for Commission meetings.

A public meeting exemption is required in order to conduct closed meetings in Florida.

The effective date of the bill is the same date that HB____ or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

Effect of the Bill

The bill makes personal identifying information, other than the name, licensure status, or licensure number, of a physician, speech-language pathologist, audiologist, or physical therapist authorized to practice under their respective compact, obtained from the coordinated data system and held by the DOH or the applicable board exempt from public records requirements, unless the laws of the state that originally reported the information authorizes disclosure. Disclosure under such circumstance is limited to the extent permitted under the laws of the reporting state.

The bill also creates a public meeting exemption for Commission meetings of each compact, or portions of such meetings, at which a matter is discussed that is specifically exempted from disclosure by federal or state law. Recordings, minutes, and records generated during an exempt portion of a Commission meeting are also exempt from public disclosure.

The bill provides that the public records and public meeting exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless saved from repeal by reenactment by the Legislature.
The bill provides a public necessity statement for the public records exemption, as required by the State Constitution, and states that the protection of such information is required under the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact and the Physical Therapy Licensure Compact in which the state must adopt in order to become a party state to each compact. Without the public records exemption, the state would be unable to effectively and efficiently implement and administer the compacts.

Additionally, the bill provides a statement of public necessity for the public meeting exemption, as required by the State Constitution, and states that each of the compacts requires any meeting in which matters that are exempt from disclosure by federal or state statute are discussed to be closed to the public. Without the public meeting exemption, the state will be prohibited from becoming a party to the compacts and would be unable to effectively and efficiently administer the compacts. The bill further provides that it is a public necessity for the recordings, minutes, and records generated during an exempt meeting be made exempt, as the release of such information would negate the public meeting exemption.

The effective date of this bill is the same date that HB1549 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law, which is July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Creates s. 456.4503, F.S., relating to Interstate Medical Licensure Compact Commission; public records and meetings exemption.
Section 2: Creates s. 468.1336, F.S., relating to Audiology and Speech-language Pathology; public records and meetings exemption.
Section 3: Creates s. 486.113, F.S., relating to Physical Therapy Licensure Compact Commission; public records and meetings exemption.
Section 4: Provides public necessity statements as required by the State Constitution.
Section 5: Provides that the bill is effective on the same date as HB___ (2024) or similar legislation takes effect.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   Vote Requirement
   Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill creates a public record exemption; thus, it requires a two-thirds vote for final passage.

   Public Necessity Statement
   Article I, s. 24(c) of the Florida Constitution requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill creates a public record exemption; thus, it includes a public necessity statement.

   Breadth of Exemption
   Article I, s. 24(c) of the State Constitution provides that an exemption must be created by general law and the law must contain only exemptions from public record or public meeting requirements. The exemption does not appear to be in conflict with the constitutional requirement.

B. RULE-MAKING AUTHORITY:

   The bill does not appear to create a need for rule-making or rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to public records and meetings exemptions; creating ss. 456.4503, 468.1336, and 486.113, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health, the Board of Speech-Language Pathology and Audiology, and the Board of Physical Therapy Practice pursuant to the Interstate Medical Licensure Compact, the Audiology and Speech-language Pathology Interstate Compact, and the Physical Therapy Licensure Compact; authorizing disclosure of the information under certain circumstances; providing an exemption from public meetings requirements for certain meetings of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-language Pathology Interstate Compact Commission, and the Physical Therapy Licensure Compact Commission; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such meetings; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing contingent effective dates.

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

Section 1. Section 456.4503, Florida Statutes, is created to read:

456.4503 Interstate Medical Licensure Compact Commission; public records and meetings exemptions.—

(1) A physician's personal identifying information, other than the physician's name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in Section 8 of s. 456.4501 and held by the department is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated database and reporting system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Interstate Medical Licensure Compact Commission established in Section 11 of s. 456.4501 at which matters specifically exempted from disclosure by federal or state law are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed

on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. Section 468.1336, Florida Statutes, is created to read:

468.1336 Audiology and Speech-language Pathology Interstate Compact Commission; public meetings and public records exemptions.—

(1) An audiologist's or a speech-language pathologist's personal identifying information, other than the audiologist's or the speech-language pathologist's name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in article IX of s. 468.1335 and held by the department or the board is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated database and reporting system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Audiology and Speech-language Pathology Interstate Compact Commission established in article VIII of s. 468.1335 at which matters specifically exempted from disclosure by federal or state law are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 3. Section 486.113, Florida Statutes, is created to read:

486.113 Physical Therapy Licensure Compact Commission; public records and meetings exemptions.—

(1) A physical therapist's personal identifying information, other than the physical therapist's name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in article VIII of s. 486.112 and held by the department or the board is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated database and reporting system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Physical Therapy Compact Commission or the executive board or any other committee of the commission established in article VII of s.

486.112 at which matters specifically exempted from disclosure by federal or state law are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 4. (1) The Legislature finds that it is a public necessity that a physician's, an audiologist's or a speech-language pathologist's, and a physical therapist's personal identifying information, other than the person's name, licensure status, or licensure number, obtained from the coordinated database and reporting system described in Section 8 of s. 456.4501, Florida Statutes, article IX of s. 468.1335, Florida Statutes, and article VIII of s. 486.112, Florida Statutes, and held by the Department of Health, the Board of Speech-Language Pathology and Audiology, and the Board of Physical Therapy Practice be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Interstate Medical Licensure Compact, the Audiology and Speech-language Pathology Interstate Compact, and the Physical Therapy Licensure Compact,

each of which the state must adopt in order to become a member state of the respective compact. Without the public records exemption, the state would be unable to effectively and efficiently implement and administer the respective compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-language Pathology Interstate Compact Commission, or the Physical Therapy Licensure Compact Commission held as provided in s. 456.4501, Florida Statutes, s. 468.1335, Florida Statutes, or s. 486.112, Florida Statutes, in which matters specifically exempted from disclosure by federal or state law are discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution.

(b) The Interstate Medical Licensure Compact, the Audiology and Speech-language Pathology Interstate Compact, and the Physical Therapy Licensure Compact require any meeting, or any portion of a meeting, of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-language Pathology Interstate Compact Commission, and the Physical Therapy Licensure Compact Commission in which the substance of paragraph (a) is discussed to be closed to the public. In the absence of a public meetings exemption, the state would be prohibited from becoming a member state of the respective compact and, thus, prohibited from effectively and efficiently administering the

respective compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting that is exempt pursuant to s. 456.4503(2), Florida Statutes, s. 468.1336(2), Florida Statutes, or s. 486.113(2), Florida Statutes, be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meetings exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 5. This act shall take effect on the same date that HB 1549 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.