Tab 1	**SPB 7016** by **HP**; Health Care					
268962	A	S	FAV	HP, Harrell	btw L.3154 - 3155:	12/12 05:33 PM
233850	A	S	FAV	HP, Harrell	btw L.3154 - 3155:	12/12 05:33 PM
769026	A	S	FAV	HP, Harrell	btw L.3154 - 3155:	12/12 05:33 PM

Tab 2	**SPB 7018** by **HP**; Health Care Innovation					
399480	A	S	RS	HP, Harrell	Delete L.111 - 138:	12/12 05:33 PM
653458	SA	S	FAV	HP, Harrell	Delete L.111 - 138:	12/12 05:33 PM
807142	A	S	FAV	HP, Harrell	Delete L.559 - 569:	12/12 05:33 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Brodeur, Vice Chair

MEETING DATE: Tuesday, December 12, 2023
TIME: 4:00—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Burton, Chair; Senator Brodeur, Vice Chair; Senators Albritton, Avila, Book, Calatayud, Davis, Garcia, Harrell, and Osgood

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	Consideration of proposed bill:		
1	**SPB 7016**	Health Care; Revising the purpose of the Dental Student Loan Repayment Program; requiring the Department of Health to provide annual reports to the Governor and the Legislature on specified student loan repayment programs; providing requirements for birth centers designated as advanced birth centers with respect to operating procedures, staffing, and equipment; authorizing certain psychiatric nurses to order emergency treatment of certain patients; creating the Training, Education, and Clinicals in Health (TEACH) Funding Program for a specified purpose, etc.	Submitted and Reported Favorably as Committee Bill Yeas 9 Nays 0
	(Preliminary Draft Available - final draft will be made available at least 48 hours prior to the meeting)		
	Consideration of proposed bill:		
2	**SPB 7018**	Health Care Innovation; Creating the Health Care Innovation Council within the Department of Health for a specified purpose; requiring the council to submit annual reports to the Governor and the Legislature; requiring the department to administer a revolving loan program for applicants seeking to implement certain health care innovations in this state; authorizing the department to contract with a third party to administer the program, including loan servicing, and manage the revolving loan fund, etc.	Submitted and Reported Favorably as Committee Bill Yeas 9 Nays 0
	(Preliminary Draft Available - final draft will be made available at least 48 hours prior to the meeting)		
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SPB 7016
INTRODUCER:	Health Policy Committee
SUBJECT:	Health Care
DATE:	December 14, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown, et al.	Brown		**HP Submitted as Comm. Bill/Fav**

I. Summary:

SPB 7016 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:

- The definition of and standards for clinical psychologists;
- The definition of and standards for psychiatric nurses;
- Mobile response team standards;
- Licensure for foreign-trained physicians;
- Certification of foreign medical schools;
- Medical faculty certificates;
- Autonomous-practice nurse midwives;
- The Florida Center for Nursing's annual report;
- 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;"
- A requirement for the AHCA to seek federal approval to implement an acute hospital care at home program in Florida Medicaid;
- 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.

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.

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

II. Present Situation:

The Health Care Workforce Shortage

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.

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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 Senate Health Policy Committee).
[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 December 4, 2023).
[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 Nov. 9, 2023).
[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 Nov 8, 2023).
[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

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, 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]

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 December 4, 2023).

[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 Nov. 30, 2023).

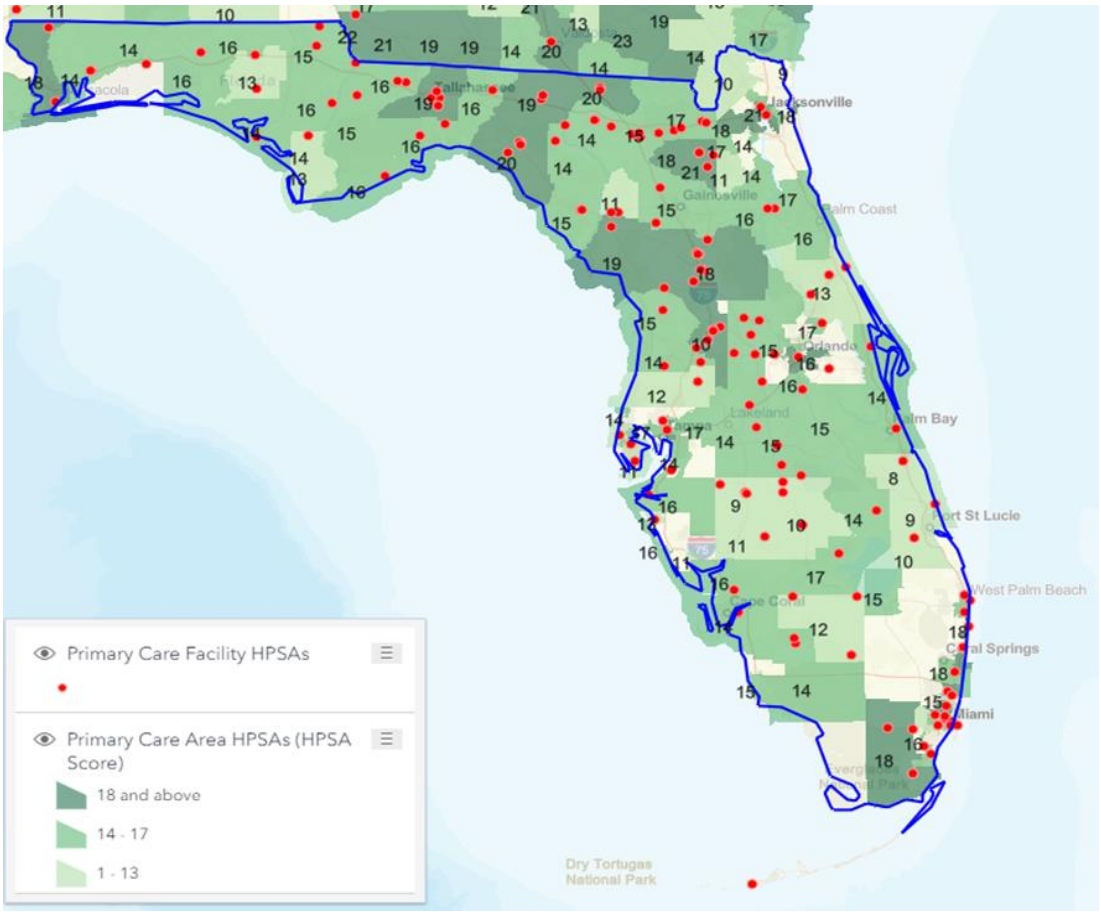
[7] *What is a Shortage Designation?*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited Nov. 30, 2023).

[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 December 4, 2023). 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 Nov. 30, 2023).

Primary Care HPSAs

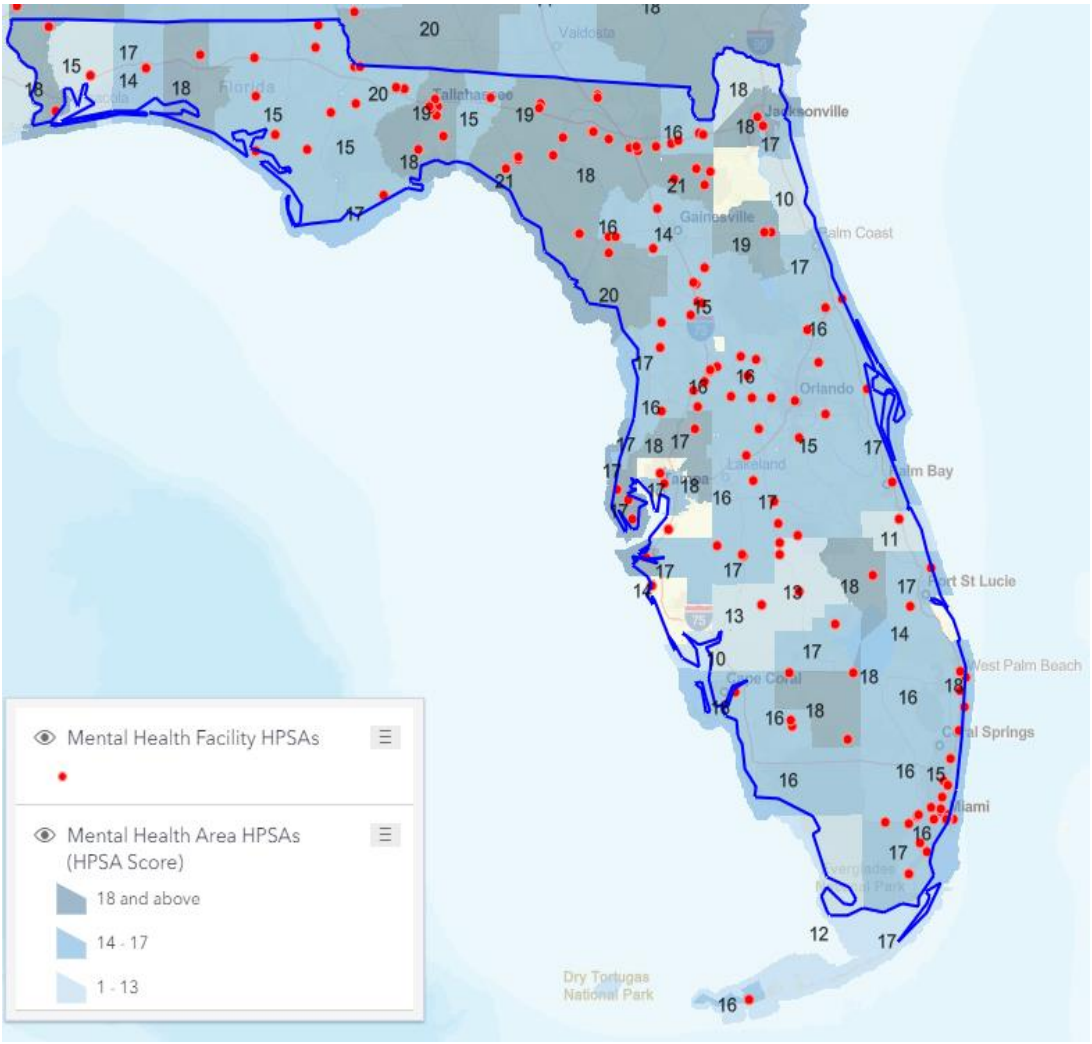
Below is a map of primary care HPSAs in Florida with their associated HPSA scores.[10]



[10] The three maps were generated with HRSAs map tool, available at https://data.hrsa.gov/maps/map-tool/, (last visited Nov. 30, 2023).

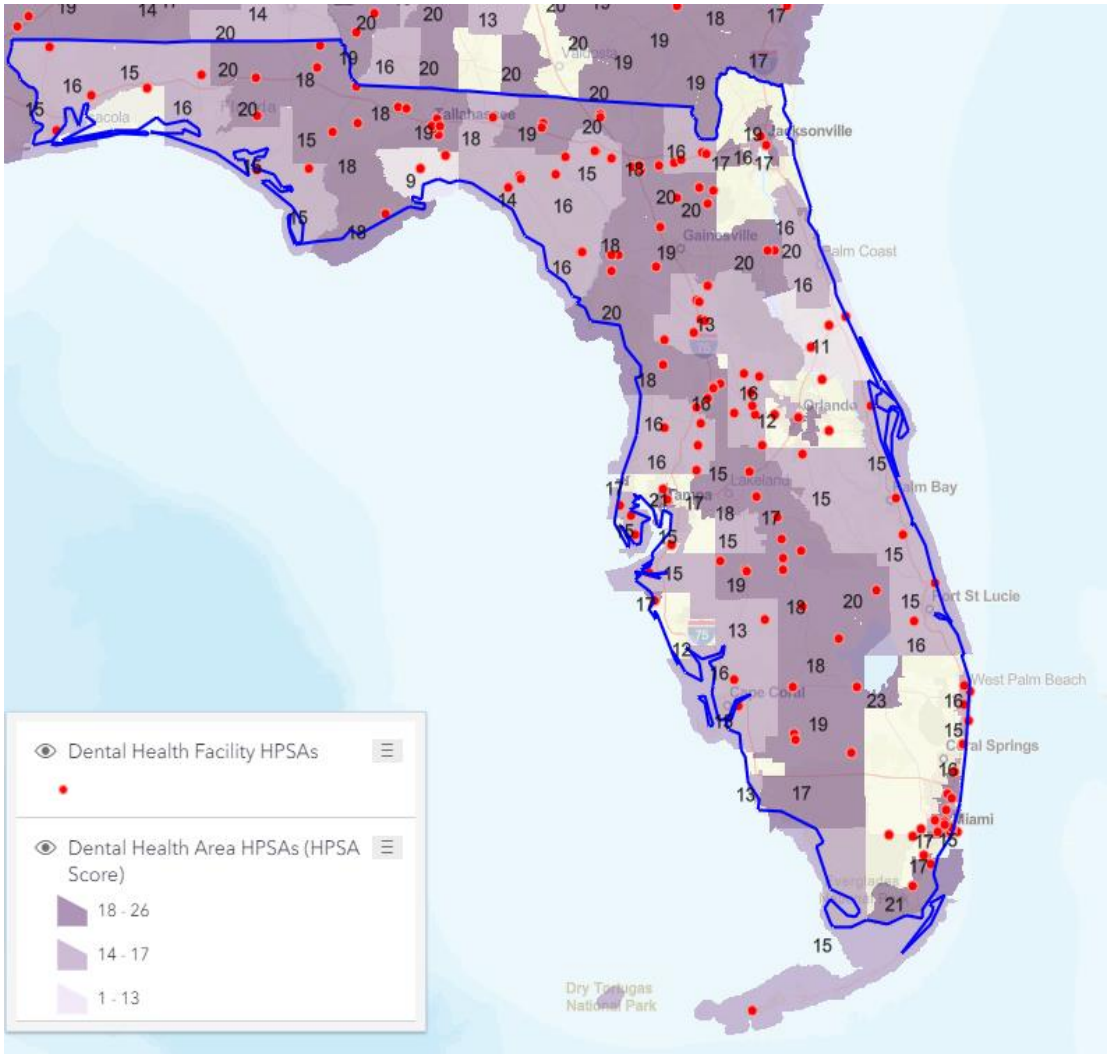
Mental Health HPSAs

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



Dental HPSAs

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

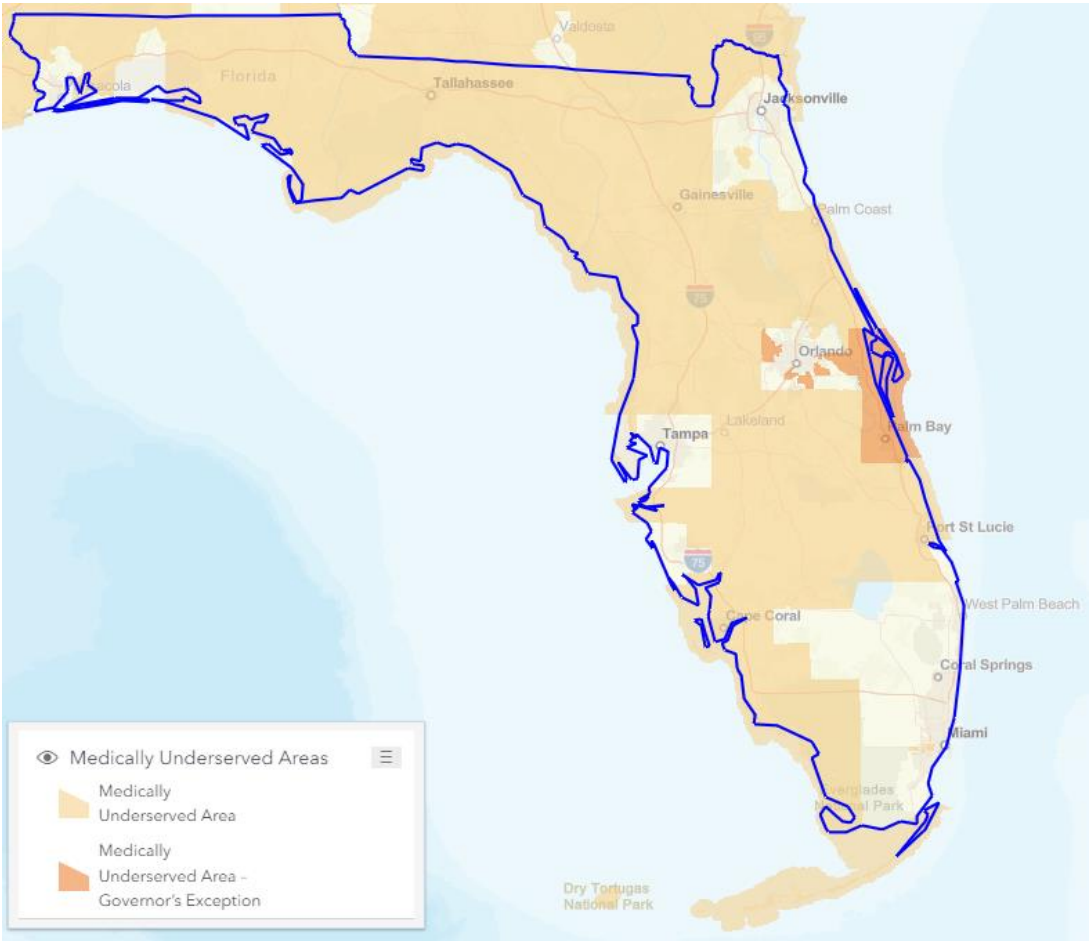


Medically Underserved Areas

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 Nov. 30, 2023).

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

[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 Nov 8, 2023). 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 Nov. 8, 2023).
[14] *Id.*

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 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 © 2021 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.

[15] Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035: 2021 Update to Projections of Supply and Demand
[16] *Id.* at V.
[17] *Id.* at VI
[18] *Id.* at 10

Florida Center for Nursing

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.

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]

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%

[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 Nov. 16, 2023).
[20] *Id.*

The Florida Department of Economic Opportunity develops a *College Projections Report* that includes the *Fastest Growing Occupations between 2020 and 2028*. Number one is the APRN. 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]

The Florida Reimbursement Assistance for Medical Education Program (FRAME) and the Dental Student Loan Repayment Program

Sections 1009.65 and 381.4019, F.S., establish student loan repayment programs for various health care practitioners and for dentists, respectively.

FRAME

The FRAME program[25] offers student loan reimbursement to various health care practitioners to offset their educational expenses in order to entice them to practice in underserved locations where there are shortages of such practitioners. The Department of Health (DOH) is authorized to reimburse as follows:

- Up to $20,000 per year for medical and osteopathic doctors with primary care specialties;[26]
- Up to $15,000 per year for autonomous advanced practice registered nurses (APRN) with primary care specialties;
- Up to $10,000 per year for APRNs and physician assistants (PA); and
- Up to $4,000 per year for licensed practical nurses (LPN) and registered nurses (RN).

[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 Nov. 16, 2023).
[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 Nov. 16, 2023).
[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 Nov. 16, 2023).
[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 Nov. 16, 2023).
[25] Section 1009.65, F.S., titles the program the "Medical Education Reimbursement and Loan Repayment Program" however, the DOH and other stake holders refer to the program as the FRAME program. To reduce confusion, this analysis will refer to the program as the FRAME program.
[26] Primary care specialties are defined as obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties which may be identified by the DOH.

Current law specifies that educational expenses that qualify for reimbursement include costs for tuition, matriculation, registration, books, laboratory and other fees, other educational costs, and reasonable living expenses as determined by the DOH.

In order to qualify for reimbursement, a listed health care practitioner, other than an autonomous APRN, must:

- Be a U.S. citizen;
- Possess a clear active Florida health care professional license;
- Provide in-person services to persons in an underserved location[27] in Florida;
- 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.[28]

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 HPSA score of at least 18.

During the 2022-2023 fiscal year, over 9,000 accounts were created in the DOH's FRAMEworks portal and 3,702 applications were submitted for loan reimbursement. Of the 3,702 applications, 2,774 were accepted, representing $40.8 million in potential awards. The amount of potential awards far exceeds the current funding for the program, which is $16 million.[29] In order to determine which applicants receive awards, the DOH computes a Frame Prioritization Score which takes into account an adjusted HPSA score for the practice location of the provider and the length of employment for the provider.[30]

DSLR Program

Section 381.4019, F.S., establishes the Dental Student Loan Repayment Program (DSLR Program). The program requires the DOH to award up to $50,000 to a dentist who, as required by DOH rule, demonstrates active employment in a public health program[31] that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or medically underserved area. Current law caps the number of dentists allowed to receive awards at 10 per state fiscal year. The DOH has not implemented the DSLR Program yet, but intends to rework the FRAMEworks portal to implement the program by February 1, 2024.[32]

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[27] Fla. Admin. Code R. 64W-4.001 defines an "underserved location" as a public health program; a correctional facility; a Health Professional Shortage Area (HPSA) as designated by Federal Health Resources and Services Administration (HRSA) 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.

[28] 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.

[29] *What is a Shortage Designation?*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited Nov. 30, 2023).

[30] Rule 64W-4.005, F.A.C.

[31] The section defines "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 the department.

[32] Email from the DOH, on Nov. 30, 2023. On file with Senate Health Policy Committee staff.

Health Care Screening Statutes

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

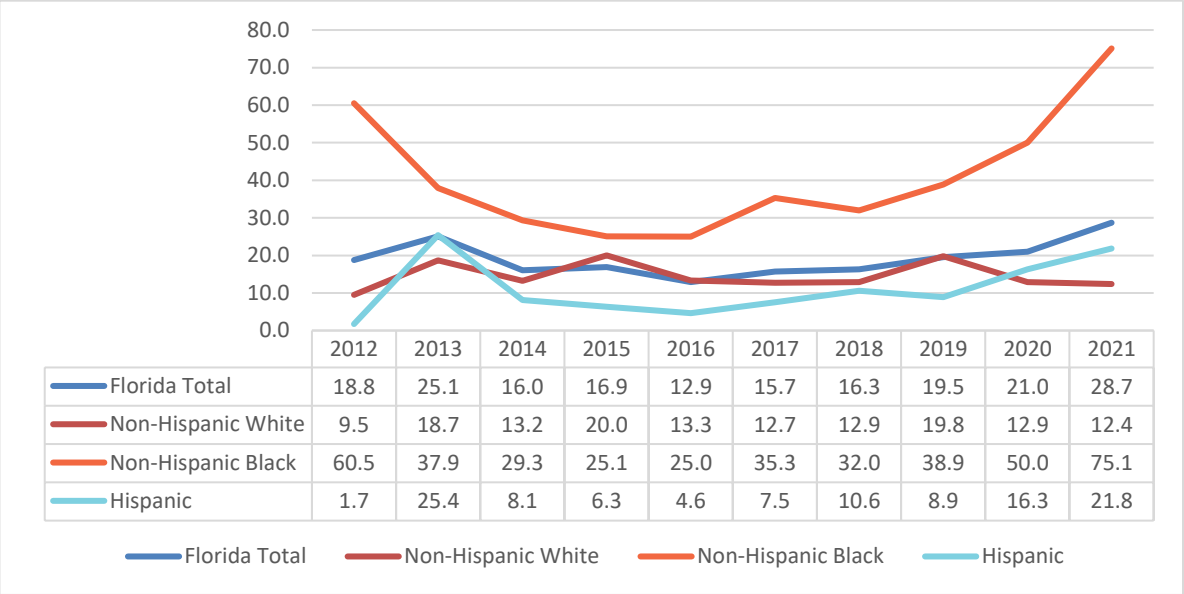
381.93	Breast and Cervical Cancer	"Mary Brogan Breast and Cervical Cancer Early Detection Program." The Department of Health, using available federal funds and state funds appropriated for that purpose, is authorized to establish the Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program to provide screening, diagnosis, evaluation, treatment, case management, and followup 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, high blood pressure screening, anemia testing, thyroid screening, cholesterol screening, diabetes screening, and assistance with smoking cessation.	Pregnancy Care Network (Contracted by DOH).

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

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.[33] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019.[34] The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births.[35] 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.[36] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[37]

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.[38] 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

[33] 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).
[34] 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 December 5, 2023).
[35] *Id.*
[36] *Id.*
[37] 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).
[38] 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 December 5, 2023).

Severe Maternal Morbidity

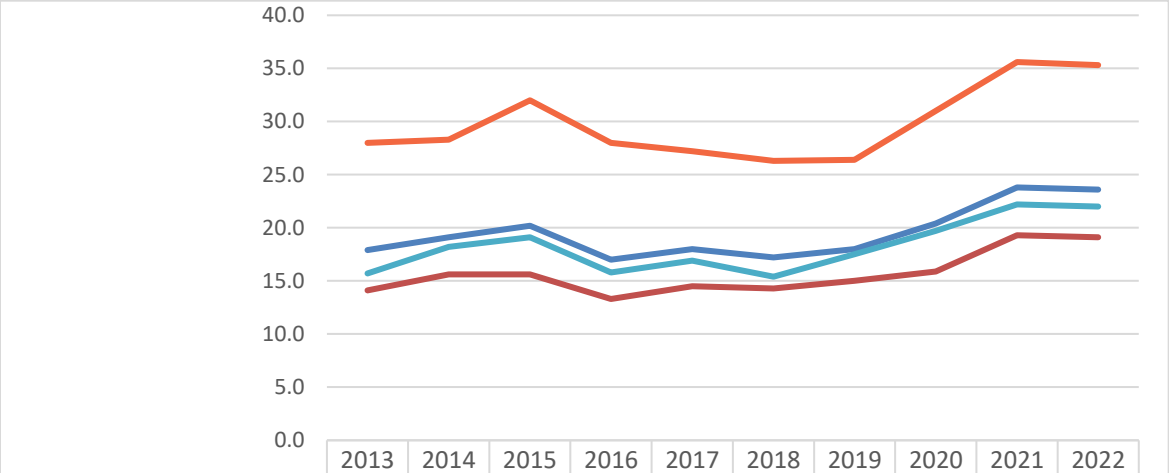
For every maternal death, 100 women suffer a severe obstetric morbidity, a life threatening diagnosis, or undergo a lifesaving procedure during their delivery hospitalization.[39] Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SMM has been steadily increasing in recent years.[40]

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.[41] 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.[42]

[39] 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 December 5, 2023).
[40] *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 December 5, 2023).
[41] 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 December 5, 2023).
[42] 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 December 5, 2023).

From 2013 to 2022, there were 51,454 cases of SMM among delivery hospitalization in Florida.[43] The following figure shows the trend over time for SMM rates in Florida per 1,000 delivery hospitalizations:[44]



	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

Similar to maternal mortality rates, rates of SMM are higher in racial and ethnic minority women.[45]

Telehealth

Telehealth effectively connects individuals and their healthcare providers when in-person care is not necessary or not possible. Using telehealth services, patients can receive care, consult with a provider, get information about a condition or treatment, arrange for prescriptions, and receive a diagnosis.[46] Telehealth and virtual care can increase access to care for rural communities, underserved and vulnerable patient populations, and to individuals unable to secure in-person care.[47]

Florida-licensed health care practitioners, registered out-of-state health practitioners, and those licensed under a multistate health care licensure compact of which Florida is a member, are

[43] 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 December 5, 2023).
[44] *Id.*
[45] 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 December 5, 2023).
[46] American Telemedicine Association, *Telehealth Basics*, available at https://www.americantelemed.org/resource/why-telemedicine/ (last visited December 5, 2023).
[47] *Id.*

authorized to use telehealth to deliver health care services to patients within the state according to the practitioners' respective scopes of practice.[48]

The 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.[49]

The DOH received funding in the 2023-2024 FY[50] to expand the pilot program to an additional 18 counties.[51] 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[52] up to the last day of their postpartum period:

- Referrals to Healthy Start's[53] coordinated intake and referral program to offer families prenatal home visiting services;
- Services and education addressing social determinants of health;[54]
- 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.[55]

[48] Section 456.47, F.S.
[49] Chapter 2021-238, Laws of Florida, codified at s. 381.2163, F.S.
[50] Chapter 2023-239, Laws of Florida, line item 435.
[51] 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 December 5, 2023).
[52] 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.
[53] 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 December 5, 2023).
[54] 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 December 5, 2023).
[55] Section 383.2163(3), F.S.

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.[56]

According to the 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.[57] 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.[58] The enrolled women were provided blood pressure cuffs, scales, and glucose monitors to remotely screen and treat common pregnancy-related complications.

Birth Centers

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.[59] Birth centers are licensed and regulated by the 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.[60] The governing body must develop and make available to all staff, clinicians, consultants, and licensing authorities, a manual that documents the policies, procedures, and protocols of the birth center.[61]

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.[62] A

[56] Section 383.2163(4), F.S.
[57] Email correspondence the DOH dated October 30, 2023 (on file with the Senate Committee on Health Policy).
[58] *Id.*
[59] 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.
[60] Section 383.307, F.S.
[61] *Id.*
[62] 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.)

mother and her infant must be discharged from a birth center within 24 hours after giving birth, except when:[63]

- 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.

A birth center must file a report with the AHCA within 48 hours of the birth, describing the circumstances and the reasons for the decision, if a mother or infant must remain in the birth center for longer than 24 hours after the birth for a reason other than those listed above.[64]

The AHCA is required to adopt rules establishing minimum standards for birth centers, which ensure:[65]

- Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety.
- Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures are established and implemented that will adequately protect patient care and provide safety.
- Licensed facilities are established, organized, and operated consistent with established programmatic standards.

To maintain quality of care, a birth center is required to:[66]

- Have at least one clinical staff[67] member for every two clients in labor;
- Have a clinical staff member or qualified personnel[68] 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;
- Ensure that all qualified personnel and clinical staff are trained in infant and adult resuscitation;
- Have qualified personnel or clinical staff who are able to perform neonatal resuscitation present during each birth;
- Maintain complete and accurate medical records;
- Evaluate the quality of care by reviewing clinical records;
- Review admissions with respect to eligibility, course of pregnancy and outcome, evaluation of services, condition of mother and newborn on discharge, or transfer to other providers; and
- Surveil infection risk and infection cases and promote preventive and corrective programs designed to minimize hazards.

[63] Section 383.318(1), F.S., and Rule 59A-11.016(6), F.A.C.
[64] Section 383.318(1), F.S.
[65] Section 383.309, F.S.; The minimum standards for birth centers are contained in Chapter 59A-11, F.A.C.
[66] Rule 59A-11.005(3), F.A.C.
[67] 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.
[68] 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.

Birth centers must ensure that their patients have adequate prenatal care and must maintain records of prenatal care for each client. Such records must be available during labor and delivery.[69]

A birth center may perform simple laboratory tests and collect specimens for tests that are requested pursuant to its protocol.[70] 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.[71]

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.[72]

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.[73]

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.[74]

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.[75] Additionally birth centers must provide a pamphlet created by the DOH on infant and childhood eye and vision disorders.

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.[76]

Birth centers must comply with provisions of the Florida Building Code and Florida Fire Prevention Code applicable to birth centers.[77] 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.[78]

[69] Section 383.312, F.S.
[70] Section 383.313, F.S.
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] Section 383.313(3), F.S.
[76] Section 383.308(1), F.S.
[77] Section 383.309(2), F.S.; Section 452 of the Florida Building Code provides requirements for birth centers.
[78] *Id.*

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.[79] A birth center must transfer the patient to a hospital if an unforeseen complication arises during labor.[80] Each facility must have an arrangement with a local ambulance service for the transport of emergency patients to a hospital, which must be documented in the facility's policy and procedures manual.[81]

Birth centers must submit an annual report to the AHCA that details, among other things:[82]

- 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;[83]
- Newborn deaths;
- Stillborn/fetal deaths; and
- Maternal deaths.

Birth centers must have written consultation agreements with each consultant who has agreed to provide advice and services to the birth center.[84] 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.[85] Consultation may be provided onsite or by telephone.[86]

Birth centers must adopt a protocol that provides information about adoption procedures. The protocol must be provided upon request to any birth parent or prospective adoptive parent of a child born in the facility.[87]

The 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.[88] The 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.[89]

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[79] Section 383.308(2)(a), F.S.
[80] Section 383.316, F.S.
[81] *Id.*
[82] Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Feb. 2015).
[83] 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 on Dec. 8, 2023).
[84] Section 383.315(1), F.S.
[85] Section 383.302(4), F.S.
[86] Section 383.315(2), F.S.
[87] Section 383.3105, F.S.
[88] Section 383.33, F.S.
[89] *Id.*

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.[90] 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.[91] 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.[92]

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.[93]

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;[94]
- 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;[95] or
- A physician, clinical psychologist,[96] psychiatric nurse,[97] 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.[98]

[90] Sections 394.451-394.47892, F.S.
[91] Section 394.459, F.S.
[92] Sections 394.4625, 394.463, and 394.4655, F.S.
[93] Section 394.463(1), F.S.
[94] Section 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[95] 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.
[96] 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.
[97] 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.
[98] Section 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.

Involuntary patients must be taken to either a public or private facility that has been designated by the Department of Children and Families as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment or transportation to the appropriate service provider.[99]

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.[100] 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.[101] 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.[102] 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.[103]

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.[104] 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.[105] 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,

[99] Section 394.455(40), F.S.
[100] Section 394.463(2)(f)-(g), F.S.
[101] *See* ss. 394.4655 and 394.467, F.S.
[102] Sections 394.4655(3)-(4), F.S., for involuntary outpatient services, and ss. 394.467(2)-(4), F.S., for involuntary inpatient services.
[103] Section 394.4655(7), F.S., for involuntary outpatient services, and ss. 394.467(6), F.S., for involuntary inpatient services.
[104] Section 394.4625(1)(a), F.S.
[105] *Id*.

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.[106] Psychological services may be rendered to individuals, couples, families, groups, and the public without regard to place of service.

The Board of Psychology within the DOH oversees the licensure and regulation of psychologists in this state.[107] To be licensed as a psychologist in this state, an individual must:

- Hold a doctoral degree from a program accredited by the American Psychological Association;[108]
- 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.[109]

An applicant may also apply for licensure by endorsement. The applicant must:

- 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.[110]

In 2023, the Florida Legislature enacted legislation authorizing Florida to join the Psychology Interjurisdictional Compact (PSYPACT).[111] Under the PSYPACT, a licensed psychologist may obtain authority to practice psychology through telehealth or to practice temporarily in-person or face-to-face in another compact state for up to 30 days.

Psychiatric Nurses

Psychiatric nurses are licensed as advanced practice registered nurses pursuant s. 464.012, F.S. The Board of Nursing within the DOH oversees the licensure and regulation of advanced practice registered nurses in this state. To be licensed as an advanced practice registered nurse in this state, an individual must:

- Hold a current license to practice professional nursing in this state;
- Be certified by the appropriate specialty board; and
- Hold a master's degree in a clinical nursing specialty area with preparation in specialized practitioner skills.[112]

For psychiatric nurses, the applicant must hold one of the following certifications recognized by the Board of Nursing:

[106] Section 490.003(4), F.S.
[107] Section 490.004, F.S.
[108] 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.
[109] Section 490.005, F.S., and r. 64B19-11.001, F.A.C.
[110] Section 490.006, F.S.
[111] Chapter 2023-140, Laws of Florida, codified at s. 490.0075, F.S.
[112] Section 464.012(1), F.S.

- Psychiatric Mental Health Nurse Practitioner Certification;
- Family Psychiatric and Mental Health Nurse Practitioner;
- Adult Psychiatric and Mental Health Nurse Practitioner; or
- Psychiatric Adult CNS.[113]

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 for the specialty, require a written examination for certification, and require completion of a formal program prior to eligibility of examination.[114]

Mental Health Services in Florida

The DCF administers a statewide system of safety-net behavioral health 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.

Managing Entities

To manage the delivery of local behavioral health services, the DCF contracts with local not-for-profit organizations with community boards to operate as behavioral health managing entities (MEs).[115] These MEs work as a management structure for the delivery of local behavioral health services and work to optimize funding and service delivery by community stakeholders, inpatient facilities, community behavioral health centers, and numerous other providers to fit each community's unique needs, ensuring access to and delivery of coordinated behavioral health care.[116] Currently, the DCF contracts with seven MEs.[117]

Mobile Response Teams (MRTs)

MRTs are behavioral health crisis response mechanisms that can be beneficial to individuals, their family, and any involved first responder when an individual is experiencing a behavioral health crisis. 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.[118] An MRT is most commonly a team of crisis-intervention trained professionals and paraprofessionals that use face-to-face professional and peer intervention, 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.[119]

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[113] Rule 64B9-4.002, F.A.C.
[114] *Id*.
[115] Section 394.9082, F.S.; Department of Children and Families, *Managing Entities, available at* https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited Nov. 27, 2023).
[116] *Id.*; Chapter 2001-191, Laws of Florida, and Chapter 2008-243, Laws of Florida.
[117] Department of Children and Families, *Managing Entities, available at* https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited Nov. 27, 2023).
[118] Department of Children and Families, *Mobile Response Teams Framework, (August 29, 2018), p. 7, available at* https://www.myflfamilies.com/sites/default/files/2022-12/Mobile%20Response%20Framework.pdf (last visited Nov. 28, 2023).
[119] *Id*.

In 1996, the Legislature integrated mobile crisis response services into Part I of ch. 394, F.S., the Florida Mental Health Act.[120] This language requires the DCF to adopt rules establishing minimum standards for services provided and personnel employed by a mobile crisis response service.[121]

In 2020, the Legislature required MRTs as a crisis service available to children and adolescents who are members of certain target populations under Part III of ch. 394, F.S. (Comprehensive Child and Adolescent Mental Health Services).[122] This requires the DCF to contract with MEs for MRTs to provide onsite mobile behavioral health crisis services to children, adolescents, and young adults ages 18 to 25 who:

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

Prior to the codification of MRTs for children and adolescents in 2020, MRTs had been forming and serving adult populations in varying capacity throughout the state under Part I of ch. 394, F.S. (the Florida Mental Health Act) and rules promulgated by the DCF.[123] While Parts I and III of ch. 394, F.S., are not in conflict, many in the behavioral health space have requested integration of these portions of law. Currently, Florida's seven MEs have contracts with 51 separate MRTs that cover all 67 Florida counties.[124]

A recent review of MRT data from 2019 through 2022 shows approximately 82 percent of MRT engagement resulted in community stabilization rather than involuntary admission or deeper penetration into the behavioral health system.[125] While MRTs generally focus on individuals under 25-years old, the DCF reports plans to use additional state funding to create additional MRTs and expand existing teams to serve more individuals of any age.[126]

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

[120] Chapter 1996-169, Laws of Florida.
[121] Section 394.457, F.S.
[122] Chapter 2020-39, Laws of Florida, codified as section 394.495, F.S.
[123] Rule 65E-5.400(6), F.A.C.
[124] Department of Children and Families, *Specialty Treatment Team Maps, Mobile Response Teams, available at* https://www.myflfamilies.com/specialty-treatment-team-maps, (last visited Nov. 28, 2023).
[125] 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.myflfamilies.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).
[126] *Id*.

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.[127]

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.[128]

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
- Five Crisis Stabilization Units
- Statewide Emergency Medical Services Treat-and-Release Providers
- All 67 County Health Departments.[129]

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

[127] *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 Dec. 4, 2023).
[128] AHCA analysis document, on file with Senate Health Policy Committee staff.
[129] *Id.*

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.[130]

Emergency Department (ED) Diversion

Hospital emergency services and care are medical screenings, examinations, and evaluations by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capacity of the facility.[131]

In the United States, approximately 13 to 27 percent of ED visits can be addressed in ambulatory settings, including urgent care centers. Diverting these patients to the appropriate setting for care could decrease health care costs by $4.4 billion. 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.[132]

Inappropriate utilization of ED services increases the overall cost of providing health care and these costs are ultimately borne by the hospital, the insured patients, and, many times, the taxpayers of the state. Therefore, Florida providers and insurers share the responsibility of providing alternative treatment options to urgent care patients outside of the ED, also known as ED diversion, through consumer education and implementation of mechanisms that will deliver care resulting in a decrease in the overutilization of emergency services on health maintenance organizations and providers.[133]

Currently, Florida Medicaid has developed and continues to create diversion tools and initiatives to decrease expenditures and improve the overall health of Medicaid recipients. Examples

[130] *Id.*
[131] Section 395.002(9), F.S.
[132] 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 Dec. 5, 2023).
[133] Section 641.31097(1), F.S.

include the collection of encounter data for the analysis of PPEs, various initiatives, e.g., the Primary Care Initiative Program, the Integrated Behavioral Health initiative, etc., and the implementation of Statewide Medicaid Managed Care (SMMC) to maximize the delivery of health care through entities and mechanisms designed to contain costs, emphasize preventive and primary care, and promote access and continuity of care.[134]

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.[135] 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.[136]

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.[137]

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.[138]

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 services 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.[139]

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[134] Section 409.9121, F.S.
[135] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Dec. 4, 2023).
[136] Section 20.42, F.S.
[137] 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 Dec. 6, 2023).
[138] *Id*.
[139] Section 20.42, F.S.

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.[140] MMA plans provide preventive, acute, behavioral, therapeutic pharmacy, and transportation services to eligible recipients.[141]

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 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."[142]

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.[143]

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:[144]

- 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

[140] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited Dec. 5, 2023).
[141] 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 Dec. 5, 2023).
[142] *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 Dec. 6, 2023).
[143] *Id*.
[144] Section 409.973(4), F.S.

- 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.[145]

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 as higher-than-expected emergency department encounters[146] or PPEs, to improve access to quality health care services while also reducing expenditures.[147]

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.[148] 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.[149]

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

[145] Section 409.967(2)(e), F.S.
[146] *Id.*
[147] 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 Dec. 4, 2023).
[148] *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 Nov. 30, 2023).
[149] *Id.*

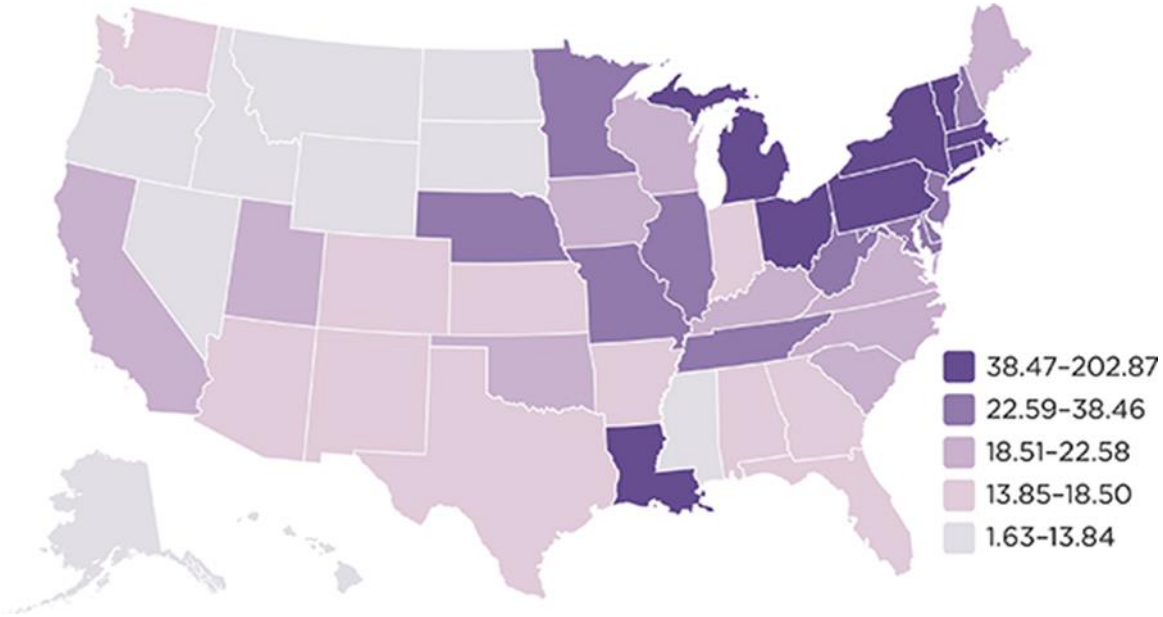
beyond the minimum licensure requirement in order to become board certified in a "pipeline" specialty (i.e., those that lead to initial board certification). The number of pipeline training positions determines the total number of physicians that the entire continuum can produce. For many years, the 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.[150]

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.[151]

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.[152]

[150] *Id.*
[151] *Id.*
[152] *Id.*



Medicaid Funding of GME

GME is an approved component of Medicaid inpatient and outpatient hospital services.[153] If a state Medicaid program opts to cover GME costs, the federal government provides matching funds.[154] Florida opts to fund GME through the Statewide Medicaid Residency Program (SMRP).[155] For fiscal year 2023-2024, the SMRP funded 6,176 residents at 83 location.[156]

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)[157]

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 deficit. For the purposes of the program, physician specialties in statewide supply-and-demand deficit are identified in the General Appropriations Act (GAA).[158]

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[153] *Id.*
[154] *Id.*
[155] Section 409.909, F.S.
[156] 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 Nov. 30, 2023).
[157] Section 409.909(5), F.S.
[158] Chapter 2023-239, Laws of Florida

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.[159] 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 specifies 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

[159] Section 409.909(6), F.S.

- Vascular surgery.

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.[160]

The OPCWI pays quarterly at an hourly rate determined by the type of provider:[161]

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.

Potentially Preventable Health Care Events (PPEs)

PPEs are encounters that could be prevented but lead to unnecessary health care services.[162]

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.[163] 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,

[160] 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 Dec. 4, 2023).
[161] *Id.* at p. 6.
[162] 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 Dec. 4, 2023).
[163] *Id.*

monitoring, or follow-up, inadequate and/or inaccessible nursing care for a nursing sensitive condition, etc.[164]

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:[165]

- Upper respiratory infections/otitis;
- Gastrointestinal diagnoses;
- Skin traumas;
- Abdominal pain;
- Viral illnesses;
- Level II musculoskeletal diagnoses;
- 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[166], but the admission could have been avoided, or when a patient is admitted and could have been treated outside of an inpatient hospital setting.[167]

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:[168]

- Septicemia;
- Heart failure;
- Pneumonia diagnoses;

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[164] 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 Dec. 4, 2023).

[165] 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 Dec. 4, 2023).

[166] 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 Dec. 4, 2023).

[167] 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 Dec. 4, 2023).

[168] 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 Dec. 4, 2023).

- 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[169] within thirty days of a hospital discharge.[170]

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:[171]

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

Acute Hospital Care at Home (AHCAH) Initiative

In response to the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services (CMS) provided a number of new flexibilities and waivers to ensure that acute hospital

[169] 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 Dec. 4, 2023).
[170] 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 Dec. 4, 2023).
[171] 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 Dec. 4, 2023).

care could continue. One of these waivers was the AHCAH initiative, which allows capable hospitals to treat appropriately selected patients with inpatient-level care in their homes.[172]

Specifically, CMS issued AHCAH flexibilities under the "Hospital Without Walls" initiative on November 25, 2020, which waived s. 482.23(b) and (b)(1) of the Medicare Hospital Conditions of Participation (CoPs), thereby 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 (RN) for care of any hospital patient. Medicare inpatient payments did not change as a result of this waiver; payments to a hospital providing AHCAH services remained the same as if the care was provided in a traditional inpatient setting. This represented the first example of payment for this level of care at home for Medicare beneficiaries.[173]

CMS has statutory authority under Section 1135 of the Social Security Act to grant either blanket (national) or individual waivers. As such, one of CMS's first decisions was to require each AHCAH waiver approval to be at the hospital/CMS Certification Number level. While this potentially limited some high-quality outpatient-based organizations, hospital providers currently have existing inpatient quality infrastructure, reporting requirements, and appreciation for the consequences of poor execution, which are considered essential for successful implementation of this program. Given the rapid rollout of this waiver, CMS also recognized that consistent guidance and clear responsibility for patient care was paramount. It was decided that patient entry to AHCAH would be limited to patients seen in EDs or those already admitted to inpatient wards. This was a deliberate choice intended to limit variability and to assuage concerns about overutilization.[174]

Waiver requests for AHCAH are divided into two categories:[175]

- Tier 1: Expedited Waivers for experienced programs that have treated at least 25 patients meeting inpatient admission criteria; and
- Tier 2: Detailed Waivers for all other submitters.

Tier 1 hospitals are required to attest that specific services and safeguards will be in place and are required to report quality metrics monthly. Tier 2 hospitals are required to give detailed explanations of how each service and safeguard will be provided and are required to report on a weekly basis. Tier 2 hospitals are also presented to CMS leadership for final approval. Other than these differences, the requirements for approval are the same; hospitals are required to provide specific inpatient services for the at-home patient, to include pharmacy needs, infusions, respiratory care including oxygen delivery, diagnostic labs and radiology, patient transportation, food services, durable medical equipment, social work and care coordination, and physical, occupational, and speech therapy. Additionally, Tier 2 hospitals are required to detail their infusion processes and protocols, response times for oxygen delivery and nebulizer treatment, and how radiology services that cannot be delivered in the home will be provided.[176]

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[172] The New England Journal of Medicine Catalyst, *Acute Hospital Care at Home: The CMS Waiver Experience, available at* https://catalyst.nejm.org/doi/pdf/10.1056/CAT.21.0338 (last visited Dec. 5, 2023).
[173] *Id*.
[174] *Id*.
[175] *Id*.
[176] *Id*.

Hospitals participating in the AHCAH initiative must also meet the following patient standards:[177]

- At least one daily appointment with a doctor of medicine (MD) or an advanced practice provider, which can be remote after the initial in-person history and physical exam performed in the hospital or ED;
- At least two in-person daily visits by a registered nurse (RN) or mobile integrated healthcare/community paramedicine professional (MIH/CP), and, as applicable, an additional daily remote RN visit to develop a nursing plan when both required visits are conducted by a MIH/CP;
- On-demand remote audio connection with an AHCAH team member who can immediately connect to the appropriate RN or physician;
- If needed, appropriate emergency personnel response to a patient's home within 30 minutes;
- Develop and utilize patient selection criteria;
- Provide volume, escalation rate, and unanticipated mortality to CMS; and
- Establish a local safety committee to review reported metrics.

AHCAH has been credited with decreasing new hospital construction in Australia and has seen extensive international adoption. In the U.S., smaller-scale efforts within the Medicare Advantage and managed care Medicaid markets have proven successful with patients, providers, and payers. However, this level of care has not been widely implemented because of the lack of a reimbursement mechanism from CMS and several limitations with the CoPs. Using emergency authority, CMS was able to waive hospital CoPs for life safety code and physical environment, which allowed for patient care to be provided in an alternate care setting, such as a patient's home for certain approved hospitals. As of October 2021, these waiver flexibilities allowed CMS to implement AHCAH in 186 hospitals in 33 states across the country, treating 1,878 patients.[178]

As of November 21, 2023, there are 12 participating Florida hospitals, approximately four percent of the AHCAH approved hospitals:[179]

- 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 (formerly Westchester Hospital);
- Tampa General Hospital;
- Orlando Regional Medical Center; and
- AdventHealth Orlando.

[177] *Id*.
[178] *Id*.
[179] Centers for Medicare & Medicaid Services, *Acute Hospital Care at Home Resources, available at* https://qualitynet.cms.gov/acute-hospital-care-at-home/resources (last visited Dec. 5, 2023).

These hospitals have been approved to offer acute inpatient services in the home, while continuing to receive Medicare reimbursement.[180]

Under the Consolidated Appropriations Act, 2023, the AHCAH initiative has been extended through December 31, 2024. Hospitals can continue to apply to participate in the initiative. If an individual is receiving care in a participating hospital and meets the requirements to receive inpatient care at home, they can continue to do so.[181]

Licensure of Health Care Practitioners

The Division of Medical Quality Assurance (MQA), within the DOH has general regulatory authority over Florida's licensed health care practitioners. The MQA works in conjunction with 22 regulatory boards and four councils to license and regulate ten unique types of health care facilities and more than 40 health care professions.[182]

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 MQA is statutorily responsible for the following boards and professions established within the division and the DOH:[183]

- 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, under the DOH 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, under the Board of Nursing 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, under the Board of Respiratory Care as provided under part V of ch. 468, F.S.;

[180] *Id*.
[181] The New England Journal of Medicine Catalyst, *Acute Hospital Care at Home: The CMS Waiver Experience*, available at: https://catalyst.nejm.org/doi/pdf/10.1056/CAT.21.0338 (last visited Dec. 5, 2023).
[182] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2022-23*, at 10, https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/MQAAnnualReport2022-2023.pdf (last visited December 5, 2023).
[183] Section 456.001(4), F.S.

- Dietetics and nutrition practice, under the Board of Medicine 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, under the Board of Medicine as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part I of ch. 483, F.S.;
- Medical physicists, under the DOH as provided under part II of ch. 483, F.S.;
- Genetic Counselors, under the DOH as provided under part III of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, under the Board of Psychology created under ch. 490, F.S.;
- School psychologists, under the Board of Psychology 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.

The DOH and the practitioner boards have different roles in the regulatory system. Boards establish practice standards by rule, pursuant to statutory authority and directives. The DOH, on behalf of the professional boards, investigates complaints against practitioners.[184] The boards determine the course of action and any disciplinary action to take against a practitioner under the respective practice act.[185] For professions for which there is no board, the DOH determines the action and discipline to take against a practitioner and issues the final orders.[186]

Board of Medicine

The Board of Medicine (BOM) is the state's regulatory arm for licensed allopathic medical doctors. The BOM is composed of 15 members appointed by the Governor and confirmed by the Senate for four year terms who serve until their successors are appointed.[187] Chapter 458, F.S., governs the licensure and regulation of the practice of allopathic medicine by the BOM in conjunction the DOH. The chapter provides, among other things, licensure requirements for medical school graduates, and licensure by endorsement requirements.

[184] Department of Health, *Investigative Services*, http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited December 5, 2023).
[185] Section 456.072(2), F.S.
[186] Professions that are regulated by the Department are certified master social workers, emergency medical technicians, genetic counselors, paramedics, radiologic technologists, and school psychologists. Florida Department of Health. *See:* Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2022-23*, at 10, https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/MQAAnnualReport2022-2023.pdf (last visited December 5, 2023)..
[187] Section 458.307, F.S. Twelve members of the BOM must be licensed physicians in good standing who are state residents and who have been engaged in the active practice or teaching of medicine for at least four years immediately preceding their appointment. One of the physicians must be on the full-time faculty of a medical school in Florida. One physician must be in private practice and a full-time staff member of a statutory teaching hospital in Florida. One physician must be a graduate of a foreign medical school. One member must be a health care risk manager. One member must be age 60 or older. The remaining three members must be residents of Florida who are not, and never have been, licensed health care practitioners.

Board of Osteopathic Medicine

The Board of Osteopathic Medicine (BOOM) is the state's regulatory board for osteopathic physicians. The BOOM is composed of seven members appointed by the Governor and confirmed by the Senate.[188] Chapter, 459, F.S., governs licensure and regulation of the practice of osteopathic medicine by the BOOM, in conjunction the DOH. The chapter provides, among other things, general licensure requirements, including by examination for medical school graduates and licensure by endorsement requirements.

Financial Responsibility

Florida-licensed allopathic and osteopathic physicians are required to maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions.[189] Physicians who perform surgeries in a certain setting or have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim.[190] Other physicians must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim.[191] Certain physicians who are exempted from the requirement to carry professional liability insurance or other financial responsibility must provide notice to their patients.[192]

With specified exceptions, the DOH must suspend, on an emergency basis, the license of any physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.[193]

[188] Section 459.004, F.S. Five members of the board must be licensed osteopathic physicians in good standing who are Florida residents and who have been engaged in the practice of osteopathic medicine for at least four years immediately prior to their appointment. At least one member of the BOOM must be 60 years of age or older. The two members must be citizens of the state who are not, and have never been, licensed health care practitioners.
[189] Sections 458.320 and 459.0085, F.S.
[190] Section 458.320(2) and 495.0085(2), F.S.
[191] Sections 458.320(1) and 459.0085(1), F.S.
[192] Sections 458.320(5)(f) and 459.0085(g), F.S.
[193] Sections 458.320(8) and 459.0085(9), F.S.

Allopathic Licensure by Examination: U.S. and Canadian Trained M.D. Applicants[194]

For an allopathic physician trained in the U.S. to be licensed by examination in Florida, an applicant must:[195]

- 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.;
- Have completed two years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry;
- Have graduated from an allopathic medical school approved by an accrediting agency recognized by the U.S. Office of Education or recognized by a governmental body of a U.S. territorial jurisdiction;
- Have completed at least one year of approved residency training; and
- Have obtained a passing score on:
  - The USMLE;[196]
  - A combination of the USMLE, the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX),[197] or the examination of the National Board of Medical Examiners (NBME) up to the year 2000; or
  - The SPEX exam,[198] if the applicant was licensed on the basis of a state board examination, is currently licensed in at least one other jurisdiction of the U.S. or Canada, and has practiced at least 10 years.

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[194] Canadian MDs and DOs who have graduated from acceptable medical schools as defined by the Model Standards for Medical Registration in Canada need only obtain permission to immigrate to come to the United States. Unlike foreign nationals of other countries, Canadians do not need visa stamps in their passports. Rather, Canadians need to receive permission to come to the U.S. and then present themselves for entry right at the border. Canadian physicians also do not need to obtain an ECFMG. A O. who graduates from one of the 17 Canadian medical schools accredited by the LCME with an M.D. or a D.O. certificate, which establishes equivalent medical education and fluency in English, and do not have to complete relevant board examinations. They are not considered to be foreign medical graduates. *See* Murthy Law Firm, U.S. Immigration Law, *Canadian Physicians and U.S. Immigration Policies available at* https://www.murthy.com/2019/08/08/canadian-physicians-and-u-s-immigration-policies/ (last visited Nov. 27, 2023). *See also* Medical Council of Canada, *Acceptable medical schools as defined in the Model Standards for Medical Registration in Canada*, *available at* https://mcc.ca/services/repository/acceptable-medical-schools-as-defined-in-the-model-standards-for-medical-registration-in-canada/ (last visited Nov. 27, 2023).

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

[196] The USMLE is a three-step examination for medical licensure in the U.S. and is owned by the FSMB and the NBME. The USMLE assesses a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care. USMLE was created in response to the need for one path to medical licensure for allopathic physicians in the United States. Before USMLE, multiple examinations, the NBME Parts examination and the FLEX, offered paths to medical licensure. It was desirable to create one examination system accepted in every state, to ensure that all licensed MDs had passed the same assessment standards – no matter in which school or which country they had trained. Today all state medical boards utilize a national examination – USMLE for allopathic physicians, COMLEX-USA for osteopathic physician. See United States Medical Licensing Examination (USMLE), *Who is USMLE? available at* https://www.usmle.org/about/ (last visited Nov. 9, 2023).

[197] The Federation of State Medical Boards of the United States, Inc., first gave the "Federation Licensing Examination" (FLEX) March 8, 1973, as a national licensing examination; and it was last given December 1993. *The Examination*, *available at* https://sos.ms.gov/ACProposed/00014082b.pdf (last visited Nov. 29, 2023).

[198] The Federation of State Medical Boards of the United States, Inc., *SPEC Information Bulletin 2021,"* available at https://www.fsmb.org/siteassets/spex/pdfs/spex-information-bulletin.pdf (last visited Nov. 29, 2023).The Special Purpose

Allopathic Licensure by Examination: Foreign-Trained Applicants

Current foreign-trained allopathic applicants must also meet the same requirements as U.S. and Canadian 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. Foreign trained applicants must also have:

- Graduated from a foreign allopathic medical school registered with the World Health Organization and certified pursuant to statute[199] as meeting the standards required to accredit U.S. medical schools and have completed at least one year of approved residency training; or
- Graduated from a foreign allopathic medical school that has not been certified pursuant to statute;[200] have an active, valid certificate issued by the Educational Commission for Foreign Medical Graduated (ECFMG);[201] passed the ECFMG's examinations; and have completed an approved residency or fellowship of at least two years in one medical specialty area that counts towards board certification by the American Board of Medical Specialties.[202]

Foreign-Trained Medical Students and Medical Graduates Practicing in Florida

Certification and Residency Programs

Foreign physicians wishing to practice medicine in Florida must be licensed by the BOM or the BOOM. All doctors, including those trained outside the U.S., are required to pass all three parts of the U. S. Medical Licensing Examination (USMLE)[203] in order to obtain a Florida medical license. An international medical graduate (IMG) must be certified by the ECFMG [204] in order to be eligible to enter U.S. graduate medical education programs (residency or fellowship), to take part III of the USMLE, and to enter the National Residency Match Program, or *The Match*.[205]

Examination (SPEX) was first given in 1988 and conceived by the Federation of State Medical Boards (FSMB) for state medical boards to use as an assessment tool when endorsing or granting licensing reciprocity to a physician licensed in another US state or Canadian province. State boards may require SPEX for endorsement of licensure, reinstatement of a license, or reactivation of a license after a period of inactivity. To take the SPEX you must hold, or have held at some point, an active, unrestricted medical license in the U.S. or Canada. Its purpose was later expanded to include cases in which state boards needed to assess a physician's competence before reinstating or reactivating a lapsed or suspended license.

[199] *See* s. 458.314, F.S. There currently are no foreign medical schools certified under this section, according to the DOH, per email to Senate Health Policy Committee staff, on file with Senate Health Policy Committee.

[200] *Id.*

[201] Section 458.311, F.S., A graduate of a foreign medical school does not need to present an ECFMG certification or pass its exam if the IMG received his or bachelor's degree from an accredited U.S. college or university, studied at a medical school recognized by the World Health Organization, has completed all of the formal requirements of the foreign medical school, except the internship or social service requirements, and 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, has passed parts I and II of the National Board Medical Examiners licensing examination or the ECFMG equivalent examination.

[202] Section 458.311, F.S.

[203] *Fla. Admin. Code Rs. 64B8-3.003, and 64B15-10.002 (2023).*

[204] The Educational Commission for Foreign Medical Graduates, ECFMG, *About Us*, available at https://www.ecfmg.org/about/ (last visited Nov. 29, 2023). The Education Commission for Foreign Medical Graduates (ECFMG) was established in 1956 to promote quality health care for the public by certifying internationally trained students for entry into United States medical schools and to practice medicine in the United States.

[205] National Residency Patch Program, *Who We Are*, available at https://www.nrmp.org/about/ (last visited Nov. 29, 2023).

The ECFMG assesses whether IMGs are ready to enter U.S. graduate medical education programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME). ACGME requires international medical graduates who enter ACGME-accredited residency or fellowship programs to be certified by ECFMG. ECFMG certification assures directors of accredited residency and fellowship programs, and the people of the U.S., that IMGs have met minimum standards of eligibility. The ECFMG:

- Evaluates the qualifications of international medical graduates (IMGs)and foreign students for entry into U.S. medical schools;
- Evaluates and verifies international medical schools;
- Evaluates and verifies physician credentials related to medical education, training, and licensure;
- Evaluates, and verifies clinical skills of international medical graduates and foreign trained physicians;
- Certifies the readiness of international medical graduates and students for entry into United States medical school through an evaluation of their qualifications; and
- Evaluates the needs of international medical graduates to become acculturated.[206]

To become certified by ECFMG, an IMG must pass the first two parts of the USMLE and two separate exams testing clinical and communication skills.[207] Once a physician receives an ECFMG certification, he or she may apply for a residency or fellowship and enter THE MATCH.[208]

Allopathic Restricted Licenses

Florida has had a long history of establishing specific pathways to restricted medical licensure for foreign trained allopathic physicians.

In 1986 the Legislature created requirements for Cuban-licensed medical doctors which authorized the BOM to issue a one-year restricted license to any Cuban- licensed medical physician who passed the Florida BOM examination and met certain criteria. It also provided that the Florida BOM examination could be translated into a foreign language at the request of at five applicants. However, by rule, the BOM adopted the FLEX as the official Florida board examination, which could not be translated into another language.[209] This pathway for Cuban

[206] The Educational Commission for Foreign Medical Graduates, ECFMG, *About Us*, available at https://www.ecfmg.org/about/ (last visited Nov. 29, 2023).
[207] The Educational Commission for Foreign Medical Graduates, ECFMG, *Certification*, available at https://www.ecfmg.org/certification/ (last visited Nov. 29, 2023).
[208] National Residency Patch Program, *Who We Are*, available at https://www.nrmp.org/about/ (last visited Nov. 29, 2023). The National Resident Matching Program (NRMP), or *The Match*, is a private, non-profit organization established in 1952 at the request of medical students to provide an orderly and fair mechanism for matching the preferences of applicants for U.S. residency positions with the preferences of residency program directors. In addition to the annual Main Residency Match that encompasses more than 47,000 registrants and 39,000 positions, the NRMP conducts Fellowship Matches for more than 70 subspecialties through its Specialties Matching Service® (SMS®). NRMP is governed by a Board of Directors that includes representatives from national medical and medical education organizations as well as medical students, resident physicians, and graduate medical education program directors.
[209] Section 458.311(6)(1986 Supp. F.S. 1985).

licensed physicians was repealed in 1995, but expired on its own terms effective October 1, 1993.[210]

In 1989, the Legislature created a pathway to full medical licensure for Nicaraguan-licensed physicians which required the BOM to issue a two-year restricted license to any Nicaraguan-licensed doctor who applied before July 1, 1992, met certain criteria, applied before July 1, 1992, and completed a specific course, or specific review course, passed the FLEX or USMLE examination. This pathway was repealed by its terms October 1, 1991.[211]

Current law authorizes the BOM to issue restricted licenses to applicants to practice medicine in Florida, for allopathic physicians under three specific circumstances:

- Certain foreign-licensed physicians;[212]
- BOM designated areas of critical need;[213] and
- Certain experienced foreign trained physicians.[214]

Restricted Licenses for Certain Foreign Licensed Physicians

A restricted licensee under s. 458.3115, F.S., permits a foreign licensed physician to practice under the direct supervision of a BOM approved full licensee and the second year being under indirect supervision. A restricted license under s. 458.3115, F.S., is valid for two years. Upon expiration a restricted licensee will become a full licensee if the restricted licensee:

- Is not under discipline, investigation, or prosecution; and
- Pays all renewal fees required of a full licensee.

The DOH must renew a restricted license upon payment of the same fees required for renewal for a full license if the restricted licensee is under discipline, investigation, or prosecution for a violation which posed or poses a substantial threat to the public health, safety, or welfare and the board has not permanently revoked the restricted license. A restricted licensee who has renewed such restricted license shall become eligible for full licensure when the licensee is no longer under discipline, investigation, or prosecution.

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.

[210] Section 20, Laws of Florida, ch. 95-145.
[211] Section 458. 311(10), F.S. (1989). Sections 1 and 42, Laws of Florida, ch. 89- 374.
[212] Section 458.3115, F.S.
[213] Section 458.310, F.S.
[214] Section 458.3124, F.S.

Restricted Licenses to Practice in BOM-Designated Areas of Critical Need

Applicants for restricted medical licenses under s. 458.310, F.S., are granted without examination, if the applicant agrees to enter into a contract for at least 24 months solely in the employ of a state or a federally funded community health center or migrant health center, at the current salary level for that position, in a BOM designated areas of critical need; and the applicant:[215]

- Meets the requirements for licensure by examination;[216] and
- Has actively practiced medicine in another jurisdiction for at least two of the immediately preceding four years or has completed board-approved postgraduate training within the year receding submission of the application.

This type of restricted licensee also requires an applicant to take and pass the licensure examination prior to the completion of the 24-month practice period.[217] If this restricted licensee breaches the terms of his or her contract he or she is prohibited from being licensed as a physician in Florida.[218]The BOM may issue up to 100 of this type of restricted licenses annually.[219]

Temporary Certificates for Practice in Areas of Critical Need

Current law does not authorize the BOOM to issue restricted licenses, but both the BOM and the BOOM may issue a temporary certificates to practice in areas of critical need to an allopathic or osteopathic physicians who will practice in those areas. An applicant for a temporary certificate must:[220]

- Be actively licensed to practice medicine in any jurisdiction of the U.S.;
- Be employed by, or practice in, a county health department, correctional facility, Department of Veterans' Affairs clinic, federally-funded community health care center, or any other agency or institution designated by the State Surgeon General and provides health care to underserved populations; or
- Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's workforce as determined by the 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.[221] The boards may deny the application, issue the temporary certificate with reasonable restrictions, or require the applicant to meet any reasonable conditions of the BOM or BOOM prior to issuing the temporary certificate if it has been more than three years since the applicant has actively practiced and the respective board determines the applicant lacks clinical competency, adequate skills, necessary medical knowledge, or sufficient clinical decision-making.[222]

[215] Section 458.310, F.S.
[216] Section 458.311, F.S.
[217] Section 458.310(3), F.S.
[218] Section 458.310(4), F.S.
[219] Section 458.310(2), F.S.
[220] Sections 458.315, and 459.0076, F.S.
[221] *Id.*
[222] Sections 458.315(3)(b) and 459.0076(3)(b), F.S.

Fees for the temporary certificate for practice in areas of critical need include a $300 application fee and $429 initial licensure fee; however, these fees may be waived if the individual is not compensated for his or her practice.[223] The temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.[224] 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.[225] A board may revoke or restrict the temporary certificate for practice in areas of critical need if noncompliance is found.[226]

Currently there are 913 out-of-state physicians with current and active temporary certificates to practice in areas of critical need in Florida. Between 2020 and 2023 the BOM has received the following numbers of applications per year, and issued the following number of temporary certificates to out-of-state physicians wishing to practice in Florida in areas of critical need.[227]

Temporary Certificates to Practice in Areas

Fiscal Years	**2000 - 2021**	**2021 - 2022**	**2022 - 2023**
Applications	117	123	119
Certificates	88	93	83

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.[228]

An allopathic physician wishing to obtain a limited license to practice in the employ of a public or private 501(c)(3) non-profit[229] 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 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

[223] Fla. Admin. Code Rs. 64B8-3.003, and 64B15-10.002 (2023).
[224] Sections 458.315(3), and 459.0076(3), F.S.
[225] Sections 458.315(3)(c), and 459.0076(3)(c), F.S.
[226] *Id.*
[227] Email from the DOH, *Temporary certificate for practice in areas of critical need*, Nov. 1, 2023, (on file with the Committee on Health Policy).
[228] Sections 458.317 and 459.0075, F.S.
[229] Section 501(c)(3) of the Internal Revenue Code.

shorter period will be sufficient. Procedures for such supervision shall be established by the BOM.

The allopathic limited license applicant must also notify the BOM within 30 days of accepting employment; and the BOM must notify the full time director of the local county health department in which a licensee intends to practice. The full time director of the local county health department must assist in the supervision of the limited licensee within his or her county and notify the BOM of any acts of the limited licensee that he or she has become aware of which would be grounds for revocation of the limited license. The BOM must establish procedures for this supervision and must review the practice of each licensee biennially to verify compliance with the restrictions.

The BOOM is also authorizes 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:[230]

- 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.[231]

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.[232]

Board of Nursing

In Florida all professional nursing is regulated by the Board of Nursing (BON) under the Nurse Practice Act.[233] The BON consists of 13 members appointed by the Governor and confirmed by the Senate; and promulgates rules for the eligibility criteria for all applicants to be licensed as licensed practical nurses (LPNs), registered nurses (RNs), advanced practice registered nurses (APRNs)[234] and autonomous advanced practice registered nurses (autonomous APRNs) and the applicable regulatory standards for the various nursing practices. Additionally, the BON is

[230] Section 459.0075, F.S., and Fla. Admin. Code R. 64B15-12.005 (2023).
[231] Section 459.0075(2), F.S.
[232] Section 459.0075(5), F.S.
[233] Chapter 465, Part I, F.S.
[234] Section 464.012, F.S. In 2018, the Florida Legislature changed the occupational title from "Advanced Registered Nurse Practitioner" to "Advanced Practice Registered Nurse," and reclassified a CNS as a type of APRN (see ch. 2018-106, Laws of Florida).

responsible for administratively disciplining any professional nurse who commits any act prohibited under ss. 464.018 or 456.072, F.S.

Advanced Practice Registered Nurses

An APRN is any person licensed in this state to practice professional nursing and who is licensed in an advanced nursing practice, including certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric nurses.[235] As of December 6, 2023, there were 62,545 licensed APRNs in the state who practice in the following nursing specialties:[236]

APRN Specialty	**Count**
Clinical Nurse Specialist	277
Certified Registered Nurse Anesthetist	7,567
Certified Nurse Midwife	1,202
Nurse Practitioner	50,041
Psychiatric Nurse	3,458
Total	**62,545**

Section 464.003(2), F.S., defines the term "advanced or specialized nursing practice" to include, in addition to practices of professional nursing that registered nurses (RNs) are authorized to perform, advanced-level nursing acts approved by the BON 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.[237] In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain *medical acts*, as opposed to *nursing* acts, as trained and authorized within the framework of an established protocol with a supervisory physician.[238]

To be eligible to be licensed as an APRN, an applicant must be licensed as a RN, have a master's degree or higher in a clinical nursing specialty with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a BON-approved nursing specialty board.[239] A nursing specialty board must:[240]

- Attest to the competency of nurses in a clinical specialty area;
- Require a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.

[235] Section 464.003(3), F.S.
[236] Email from the DOH, *Registered Autonomous APRNs under 464.0123 and Certified APRNs under Section 464.012 F.S.,* Dec. 6, 2023, (on file with the Committee on Health Policy).
[237] Section 464.012(3)-(4), F.S.
[238] Section 464.003, F.S., and s. 464.012, F.S.
[239] Section 464.012(1), F.S., and Fla. Admin. Code R. 64B9-4.002 (2023).
[240] Fla. Admin. Code R.64B9-4.002(3), (2023).

APRNs may perform only nursing practices, and medical practices they have been trained for and are delineated in a written protocol with a physician. A physician providing primary health care services may supervise APRNs in up to four medical offices,[241] in addition to the physician's primary practice location. If the physician provides specialty health care services, then only two medical offices in addition to the physician's primary practice location may be supervised.[242] A special limitation applies to dermatology services. If the physician offers services primarily related to dermatologic or skin care services (including aesthetic skin care services other than plastic surgery), at a medical office that is not the physician's primary practice location, then the physician may only supervise one medical office.[243]

In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs to prescribe controlled substances beginning in 2017. [244] The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,[245] as well as requiring CE credits related to controlled substances prescribing. Under a written protocol with a physician, an APRN may:

- Prescribe, dispense, administer, or order any drug;[246]
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by BON rule;
- Order diagnostic tests and physical and occupational therapy;
- Perform certain physical examinations previously reserved to physicians and physician assistants, such as examinations of pilots;[247] and
- Perform certain acts within his or her specialty.[248]

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, without a supervising physician or written protocol with a physician.[249] The BON has defined primary care by rule to include the "physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance,

[241] The supervision limitations do not apply in certain facilities such as hospitals, colleges of medicine or nursing, nonprofit family-planning clinics, rural and federally qualified health centers, nursing homes, assisted living facilities, continuing care facilities, retirement communities, clinics providing anesthesia services, rural health clinics, community-based health care settings, student health care centers, school health clinics, or other government facilities. Sections 458.348(3)(e), and 459.025(3)(e), F.S.
[242] Sections 458.348, and 459.025, F.S.
[243] *Id*.
[244] Chapter 2016-224, Laws of Florida.
[245] Pursuant to s. 893.03(2), F.S., a schedule II substance has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. In Florida, an APRN may only prescribe a 7-day supply of a schedule II controlled substance, except the limitation does not apply to certain psychiatric prescribing psychiatric medications. Section 456.42, F.S., limits the amount of schedule II opioids that may be prescribed for acute pain by any prescriber to a 3-day supply, with certain exceptions.
[246] Controlled substances may only be prescribed or dispensed if the APRN has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.
[247] Section 310.081, F.S.
[248] Sections 464.012(3)-(4), and 464.003, F.S.
[249] Section 464.0123(3)(a)1., F.S.

counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions."[250]

To engage in autonomous practice, an APRN must register with the BON. To register, an APRN must hold active and unencumbered Florida RN and APRN licenses and must have:

- Completed at least 3,000 clinical practice hours or clinical instructional hours[251] 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;[252] and
- Any other registration requirements provided by BON rule.

Current law requires autonomous APRNs to obtain and maintain liability coverage at least $100,000 per claim with a minimum annual aggregate of at least $300,000. This requirement does not apply to autonomous APRNs who:

- Practice exclusively as an officer, employee, or agent of the federal government or of the state or its agencies or subdivisions;
- Are not practicing in this state and whose registration is inactive;
- Practices only in conjunction with teaching duties at an accredited school or its main teaching hospitals; and
- Hold an active autonomous APRN registration, but are not actively engage in autonomous practice. Such practitioners must notify DOH if they resume autonomous APRN practice and obtain the requisite liability coverage.

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.[253]

Current law directs the DOH to conspicuously distinguish the autonomous APRN practitioner profiles from the APRN profiles.

An autonomous APRN must provide also each new patient with written information about his or her qualifications before or during the initial patient encounter. An autonomous APRN engaged

[250] Fla. Admin. Code R. 64B9-4.001(12), (2023).
[251] 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.
[252] *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).
[253] 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.

in primary care practice is authorized to perform the following without supervision or a written protocol with a physician:[254]

- Admit, discharge, or manage the care of a patient requiring the services of a health care facility, as authorized under federal law or BON rule;
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician, except for the certification required for the use of medical marijuana; [255]
- Certify causes of death and sign, correct, and file death certificates;
- Subject a person to involuntary examination under the Baker Act;[256] and
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

A certified nurse midwife may perform midwifery services[257] autonomously only if he or she has a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician. An autonomous APRN may not perform any surgical procedures that go below the subcutaneous tissue.

Current law imposes safeguards to ensure autonomous APRNs practice safely, similar to those for physicians.[258] It defines an adverse incident as an event over which the APRN could exercise control and which is associated with a nursing intervention, rather than a condition for which such intervention occurred, which results in at least one of the following:

- A condition that requires the transfer of the patient to a hospital;
- Permanent physical injury to the patient; or
- Death of the patient.

If such an event occurs, the autonomous APRN must report the adverse incident to the DOH, in writing, within 15 days of the occurrence or discovery of the occurrence. The DOH must review the adverse incident to determine if the autonomous APRN committed any act that would make the autonomous APRN subject to disciplinary action.

As of December 5, 2023, of the 62,545 licensed APRNs in Florida there were 11,201 current and active registered autonomous APRNs in Florida practicing in one of five nursing pathways which break down as follows:

- 9,933 certified nurse practitioner (CNP);
- 83 certified nurse midwife (CNM);
- 20 clinical nurse specialist (CNS);
- 72 certified registered nurse anesthetist (CRNA); or
- 1,093 certified psychiatric nurse.[259]

[254] Section 464.0123(3), F.S.
[255] Section 381.986, F.S.
[256] Section 394.463, F.S.
[257] *See* s 464.012(4)(c), F.S.
[258] *See* ss. 458.351 and 459.026, F.S.
[259] Email from the DOH, *Autonomous APRNs*, Dec. 5, 2023, (on file with the Committee on Health Policy).

Regulation of Audiology and Speech-Language Pathology

Audiologists and speech-language pathologists are licensed and regulated by Board of Speech-Language Pathology and Audiology pursuant to Part I of ch. 468, F.S. To qualify for licensure, an applicant must:[260]

- Meet education and clinical experience requirements:
  - An audiologist must hold a doctoral degree and have 300 hours of supervised experience with at least 200 hours in the area of audiology. If an applicant for licensure as an audiologist holds a master's degree conferred before January 1, 2008, the applicant must document that prior to licensure he or she completed one year clinical work experience.
  - A speech-language pathologist must hold a master's degree or have completed the academic requirements of a doctoral program, with a major emphasis in speech-language pathology and 300 hours of supervised experience with at least 200 hours in that area of speech-language pathology.
- Meet professional experience requirement:
  - An audiologist must have 11 months of professional employment experience.
  - A speech-language pathologist must have nine months of professional experience.
- Pass the Praxis examination no more than three years prior to the date of application.

An audiologist or speech-language pathologist who holds a valid license in another U.S. state or jurisdiction may apply for licensure by endorsement if the criteria for issuance of such license were substantially equivalent or more stringent than Florida's requirements.[261] Additionally, an individual who 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 qualifies for licensure.[262]

The current licensure application fee is $75 and is non-refundable.[263] If a license is approved, the initial license fee is $200.

Regulation of Physical Therapy

Physical therapists and physical therapist assistants are licensed and regulated by the Board of Physical Therapy under the ch. 486, F.S. To be licensed as a physical therapist or physical therapist assistant, an applicant must:

- Be at least 18 years old;
- Be of good moral character;
- Meet educational requirements:
  - For a physical therapist, has received a degree from a physical therapist educational program accredited by the Commission on Accreditation in Physical Therapy Education;

[260] Florida Department of Health, Board of Speech-Language Pathology and Audiology, available at https://floridasspeechaudiology.gov/licensing/ (last visited December 7, 2023). The necessary semester hours needed for an academic degree vary depending on when the degree was earned.
[261] Section 468.1185(3)(a), F.S.
[262] Section 468.1185(3)(b), F.S.
[263] Florida Department of Health, Board of Speech-Language Pathology and Audiology, available at https://floridasspeechaudiology.gov/licensing/ (last visited December 7, 2023).

    - For a physical therapist assistant, has received a degree as a physical therapist assistant from a physical therapist assistant educational program accredited by the Commission on Accreditation in Physical Therapy or was enrolled between July 1, 2014, and July 1, 2016, in a physical therapist assistant school in Florida which was accredited at the time of enrollment and graduated no later than July 1, 2018;
- Pass the appropriate licensure examination developed by the Federation of State Boards of Physical Therapy within five attempts;[264] and
- Pass an examination on Florida laws and rules.[265]

An applicant may be entitled to licensure without examination if he or she holds an active license in another jurisdiction and presents evidence of having passed a licensing examination of another jurisdiction.[266] The board must determine that the standards of that other jurisdiction are as high as the standards in Florida.

Licensure Discipline

Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations under the Division of Medical Quality Assurance (MQA) in DOH. Section 456.072, F.S., specifies acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Chapter 456, F.S., and the individual practice acts identify actions that constitute grounds for which disciplinary actions may be taken against a health care license. Some portions of the licensure discipline process are public and some are confidential.[267]

MQA reviews complaints to determine if the complaint is legally sufficient.[268] A determination of legal sufficiency is made if the ultimate facts show that a violation has occurred.[269] The complaint is forwarded for investigation if it is found to be legally sufficient. MQA notifies the complainant by letter to advise whether the complaint will be investigated, additional information is needed, or the complaint is being closed because it is not legally sufficient.[270] Complaints that involve an immediate threat to public safety are given the highest priority.

A probable cause panel of the appropriate board reviews all evidence and information gathered during the investigation and determines whether the case should be escalated to a formal administrative complaint, closed with a letter of guidance, or dismissed.[271] If a formal

[264] If an applicant fails the licensure examination five times, he or she is precluded from licensure, regardless of the jurisdiction through which the examination is taken.
[265] Sections 486.031 and 486.102, F.S., and r. 64B17-3.002, F.A.C.
[266] Section 486.081, F.S., and r. 64B17.3001(3), F.A.C.
[267] Florida Department of Health, Division of Medical Quality Assurance, *Enforcement Process*, available at https://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/process-chart.pdf (last visited December 7, 2023).
[268] Section 456.073, F.S.
[269] Florida Department of Health, *Administrative Complaint Process – Consumer Services*, available at https://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html (last visited December 7, 2023).
[270] *Id*.
[271] Florids Department of Health, Medical Quality Assurance, *A Quick Guide to the MQA Disciplinary Process Probable Cause Panels*, available at http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/_documents/a-quick-guide-to-the-mqa-disciplinary-process.pdf (last visited December 7, 2023).

administrative complaint is filed and it involves disputed issues of material fact, the case may be heard before an administrative law judge (ALJ) and the ALJ will issue a recommended order.[272] The issue of whether a licensee has violated the laws and rules regulating the profession, including determining the reasonable standard of care, is a conclusion of law determined by the board.[273] The appropriate board will issue a final order in each disciplinary case.[274]

Interstate Licensing Compacts

An interstate compact is a contract between two or more states. It carries the force of law and may establish uniform guidelines, standards, or procedures for the compact's member states.[275] Interstate compacts addressing regulatory matters may be structured quite differently. There are generally two types of compact models: mutual recognition and expedited licensure.[276]

Under a mutual recognition model, a health care practitioner receives a multistate license from the compact state in which the licensee has established residence or purchases "privileges" from the compact.[277] The multistate license authorizes the holder to practice in any of the other states who are members of the compact, as long as he or she maintains residence in the state in which he or she is initially licensed. Licensees are generally bound to the renewal and continuing education requirements of the state in which they reside.[278] The Nurse Licensure Compact, Physical Therapy Licensure Compact, and the Audiology and Speech-Language Pathology Interstate Compact are examples of mutual recognition compacts.

An expedited licensure model requires a health care practitioner to apply for licensure in each state they intend to practice, but the compact makes the application process more efficient by providing centralization application requirements.[279] Under this model, officials in the applicant's principal state of licensure determine if the applicant qualifies for expedited licensure; and if so, the applicant may receive an expedited license from other member states. The Interstate Medical Licensure Compact for physicians is an expedited licensure model.

Florida has enacted three health care practitioner compacts – the Nurse Licensure Compact enacted in 2016,[280] the Professional Counselors Licensure Compact enacted in 2022,[281] and the Psychology Interjurisdictional Compact enacted in 2023.[282]

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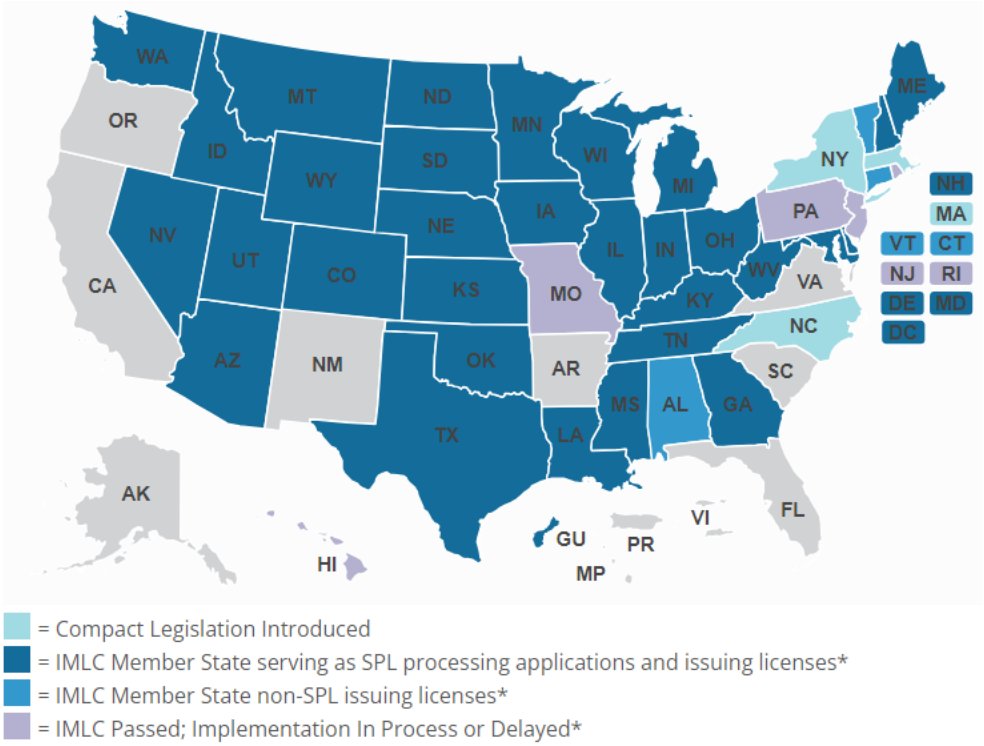
[272] Section 456.073(5), F.S.
[273] *Id*.
[274] Section 456.073(6), F.S.
[275] *See* What is a Compact? Audiology and Speech Language Pathology, available at: https://aslpcompact.com/wp-content/uploads/2019/08/80057-What-is-a-Compact_Final.pdf (last visited December 7, 2023).
[276] The Council for State Governments, *Occupational Licensure: Interstate Compacts in Action*, available at https://licensing.csg.org/wp-content/uploads/2019/07/OccpationalInterstateCompacts-InAction_Web.pdf (last visited December 7, 2023).
[277] *Id*.
[278] *Id*.
[279] *Id*.
[280] Section 464.0095, F.S.
[281] Section 491.017, F.S.
[282] Section 490.0075, F.S.

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC) offers an expedited pathway to licensure for qualified physicians.[283] Physicians complete a single application and receive separate licenses from each state they intend to practice. The issuance of the license remains based in the individual state. Under the IMLC, a physician must:

- Designate a state of principal license;
- Have graduated from an accredited medical school or a school listed in the International Medical Education, or its equivalent;
- Have successfully completed accredited graduate medical education;
- Passed each component of the United States Medical Licensing Examination, Comprehensive Osteopathic Medical Licensing Examination of the United States, or equivalent examination;
- Hold a current specialty or a time-unlimited certification;
- Not have a history of disciplinary action or controlled substance action against his or her medical license;
- Not have any criminal history;
- Not currently be under investigation; and
- Pay a $700 application fee to the IMLC.[284]

The IMLC became operational in 2017 and has been enacted by 37 states, the District of Columbia, and the territory of Guam, as seen in the illustration below.[285]



[283] IMLC, *A Faster Pathway to Physician Licensure*, available at https://www.imlcc.org/a-faster-pathway-to-physician-licensure/ (last visited December 7, 2023).
[284] *Id.*
[285] *Id.*

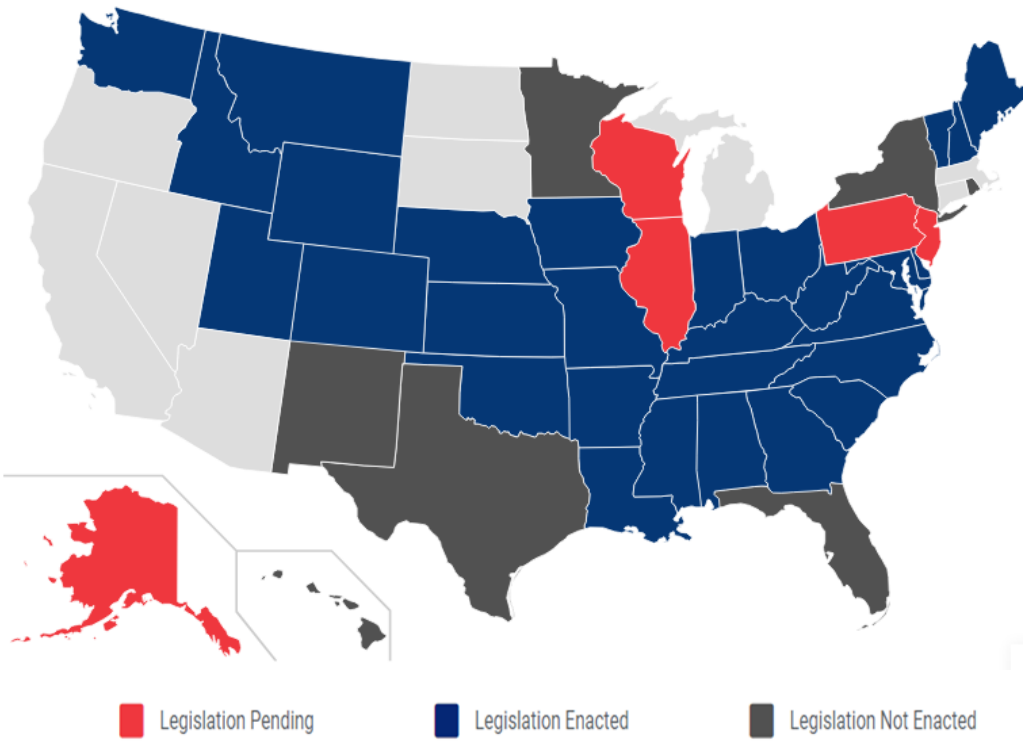
Audiology and Speech-Language Pathology Interstate Compact

The Audiology and Speech-Language Pathology Interstate Compact (ASLP Compact) is a mutual recognition compact that allows an audiologist or speech-language pathologist who holds a license in his or her home state to apply for privileges to practice in another member state under the ASLP Compact. Such audiologist or speech-language pathologist is authorized to practice face-to-face or through telehealth in a member state without having to become licensed in that state.

To qualify for compact privileges, the audiologist or speech-language pathologist must have:

- An active, unencumbered license in his or her own state;
- Earned an accredited degree;
- Completed a supervised practicum and approved national examination;
- For speech-language pathologist, complete a supervised post-graduate professional experience;
- No disqualifying criminal history; and
- A valid Social Security Number or National Practitioner Identifier.[286]

Although the ASLP Compact began operations in 2022, it is not anticipated to be fully operational and processing applications for compact privileges until early 2024.[287] Twenty-nine states have enacted the ASLP Compact, as seen in the illustration below.



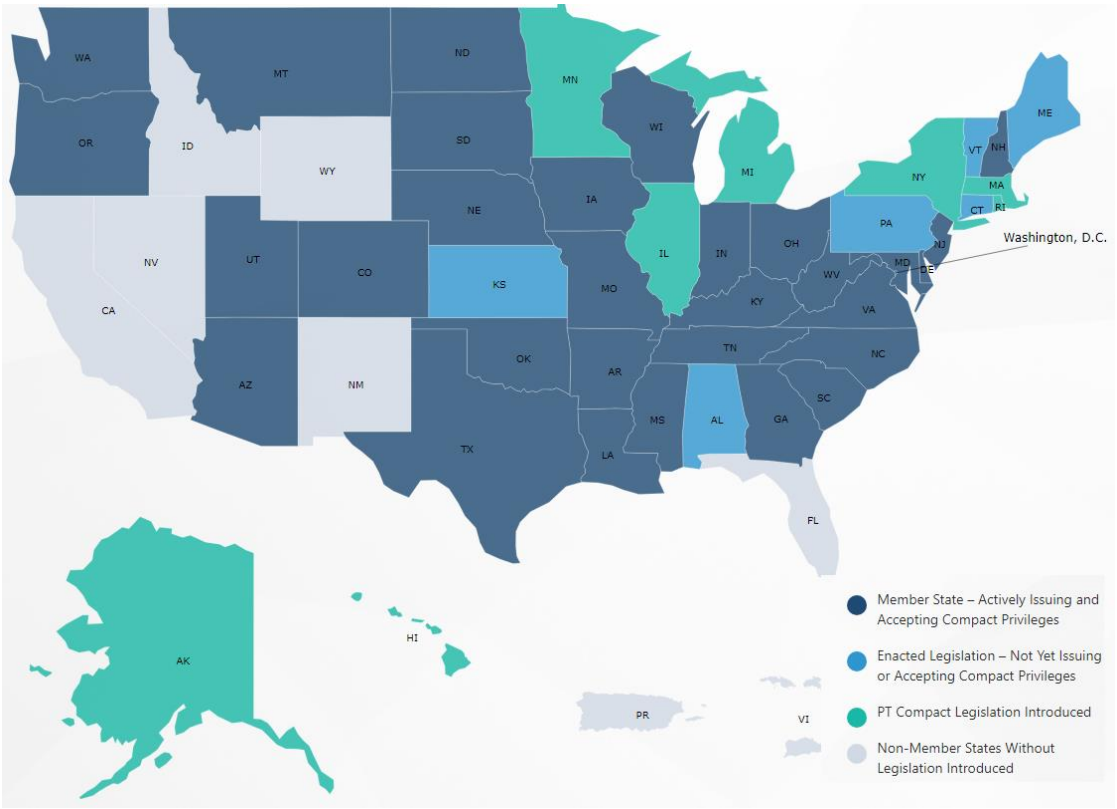
[286] ASLP Compact, *Frequently Asked Questions*, available at https://aslpcompact.com/faq/ (last visited December 7, 2023).
[287] ASLP Compact, *ASLP-IC: Audiology & Speech-Language Pathology Interstate Compact*, available at https://aslpcompact.com/ (last visited December 7, 2023).

Physical Therapy Compact

The Physical Therapy Compact (PT Compact) is a mutual recognition compact that allows a physical therapist or physical therapist assistant who holds a license in his or her home state to apply for privileges to practice in another member state under the PT Compact.[288] To be eligible for compact privileges, a physical therapist or physical therapist assistant, must:

- Hold a current, valid, unencumbered license in his or her home state, which must be actively issuing and accepting compact privileges;
- Not have had any disciplinary action against his or her license within the previous two years;
- Successfully complete a jurisprudence examination, if required by the member state for which the applicant is seeking privileges; and
- Pay the $45 PT Compact fee and the fee charged by the member state, if any.[289]

The PT Compact has been enacted by 37 states as seen in the illustration below.[290]



[288] PT Compact, *How to Get Compact Privileges*, available at https://ptcompact.org/How-to-Get-Privileges (last visited December 7, 2023).
[289] *Id*. See also, PT Compact, *Fee and Jurisprudence Table*, available at https://ptcompact.org/Compact-Privilege-Fee-Jurisprudence-and-Waiver-Table (last visited December 7, 2023).
[290] PT Compact, *Compact Map*, available at https://ptcompact.org/ptc-states (last visited December 7, 2023).

Sovereign Immunity for Charitable Care

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[291] 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.[292]
- 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.

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.[293] 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.[294] As part of a lab

[291] "Governmental contractor" is defined as the DOH, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.
[292] "Low-Income" is defined as A person who is Medicaid-eligible under Florida law; a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.
[293] Section 1002.32(2), F.S.
[294] Section 1002.32(4), F.S.

school's mission, there must be an emphasis on mathematics, science, computer science, and foreign languages.[295] 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:[296]

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

A university is limited to one lab school, except for a charter lab school or one that serves military families near a military installation.[297] 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[298]and the Florida State University Collegiate School in Bay County.[299] 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).[300]

III. Effect of Proposed Changes:

FRAME and DSLR Program

The bill amends two sections and creates one section of the Florida Statutes to makes changes to FRAME and the DSLR Program. The bill transfers the FRAME program from s. 1009.65, F.S., to s. 381.402, F.S., so that both FRAME and the DSLR Program are located in the same chapter of the statutes. The bill also declares that FRAME and the DSLR Program are meant to support the state Medicaid program.

Specific to the DSLR Program, the bill expands the program to include dental hygienists and to include private dental practices that are located in dental health professional shortage areas as eligible practice locations for dentists and dental hygienists who want to apply for reimbursement. The bill specifies that 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.

Specific to the FRAME program, 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

[295] Section 1002.34(3), F.S.
[296] Florida Department of Education, *Superintendents*, https://www.fldoe.org/accountability/data-sys/school-dis-data/superintendents.stml (last visited Dec. 5th, 2023)
[297] Section 1002.32(2), F.S.
[298] *Id.*
[299] Florida State University, The Collegiate School Panama City, https://tcs.fsu.edu/ (last visited Dec. 5, 2023).
[300] Section 1002.33(6)(g), F.S.

consolidates autonomous ARNPs with the other practitioner types and eliminates specific requirements for such ARNPs to qualify for the program. The bill lengthens the amount of time over which awards may be given from year-to-year to over four years and increases the maximum award amounts for every practitioner as follows (the following amounts reflect the total amount awarded over four years):

- Up to $150,000 for physicians;
- Up to $90,000 for ARNPs registered to engage in autonomous practice;
- Up to $75,000 for non-autonomous ARNPs and PAs;
- Up to $75,000 for mental health professionals; and
- Up to $45,000 for LPNs and RNs.

The bill specifies that a practitioner may only receive an award for one four-year period and requires the DOH to award 25 percent of the practitioner's principal loan amount at the time he or she applies for the program at the end of each year.

For both FRAME and the DSLR Program, the bill requires that practitioners 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. In order to qualify, the hours must be verifiable in a manner determined by the DOH.

Additionally, the bill requires the AHCA to seek federal authority to use Title XIX[301] matching funds for FRAME and the DSLR Program, and the bill provides a sunset date for both programs of July 1, 2034.

Student Loan Repayment Program Reporting

The bill creates s. 381.4021, F.S., to establish reporting requirements for FRAME and the DSLR Program. The bill requires the DOH to provide an annual reporting 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.
- The practice setting in which each practitioner who received a loan payment practices.

The bill also requires the DOH to contract with an independent third party to develop and conduct a study to evaluate the effectiveness of FRAME and the DSLR Program. The bill requires the 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 either FRAME or the DSLR Program must furnish any information requested by the DOH for the study or the DOH's annual reporting requirements.

[301] Title XIX of the federal Social Security Act creates the Medicaid program and provides federal matching funds for states that participate in Medicaid

Health Care Screening and Services Grant Program

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.

Advanced Birth Centers

The bill amends multiple sections of the Florida statutes related to birth center licensure to create a new designation for birth centers as advanced birth centers (ABC). The bill defines an ABC as 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. The bill also adds a definition for the term "medical director" to mean a person who holds an active unrestricted license as a physician under ch. 458 or ch. 459, F.S.

To be designated as an ABC, a birth center is required to maintain all of the statutory requirements for both birth centers and advanced birth centers and:

- Be operated and staffed 24 hours per day, 7 days per week.
- 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.
- Have at least one properly equipped, dedicated surgical suite for the performance of cesarean deliveries.
- 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.
- 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.
- Meet all standards adopted by rule for birth centers, unless specified otherwise, and advanced birth centers pursuant to s. 383.309, F.S.
- Comply with the Florida Building Code and Florida Fire Prevention Code standards for ambulatory surgical centers.
- Qualify for, enter into, and maintain a Medicaid provider agreement with the 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 the AHCA to establish in rule a procedure for designating birth centers as ABCs and states that 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.

Laboratory Services

ABCs are required to 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 the 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.

Surgical Services

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.

Administration of Analgesia and Anesthesia

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 postanesthesia recovery period until the patient is fully alert.

Intrapartal Use of Chemical Agents

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.[302]

ABCs are required 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.

An ABC may 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 the AHCA. If a mother or infant is retained longer than the allowed time, a report must be filed with the AHCA within 48 hours of the scheduled discharge time which must describe the circumstances and reasons for keep the patient.

[302] 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, 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 Dec. 5, 2023).

Hospital Requirements

Prohibition on Accepting Payments for Clinicals

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.

Emergency Department Diversion Plan

The bill also requires all hospitals with emergency departments (ED), including hospital-based off-campus EDs, to submit a diversion plan to the 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 the AHCA prior to first licensure or licensure renewal. The bill requires all hospitals to submit data to the AHCA demonstrating the effectiveness of its ED diversion plan annually and update the plan as necessary, or as directed by the AHCA, prior to licensure renewal.

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

- A partnership agreement with one or more nearby 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, for patients enrolled in the Medicaid program and are members of a Medicaid managed care plan, the ED diversion plan must include outreach to that patient's managed care plan and coordination with the plan for establish a relationship between the patient and a primary care setting. The AHCA is required to establish a process for the hospital to share the patient's updated contact information with the managed care plan.

Participation in the Florida Health Information Exchange (FHIE) program

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.

Statewide Medicaid Residency Program (SMRP)

Slots for Doctors Program

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[303] that receives state funds under the SMRP, including, but not limited to intergovernmental transfers, to annually report data to the AHCA.

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.

[303] 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.

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.

Florida Center for Nursing Annual Report

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.

Charitable Care at Free Clinics

The bill amends s. 766.1115, F.S., to increase the maximum income a patient can have in order to be considered low-income from 200 percent to 300 percent of FPL. In order for a free clinic to qualify as a health care provider and be eligible for sovereign immunity under the section, the free clinic must serve exclusively low-income patients. This change will increase the number of people a free clinic can serve while still maintaining its eligibility for sovereign immunity under the section.

Lab 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.

LINE

The bill amends the LINE program in s. 1009.8962, F.S., in order to include independent schools, colleges, or universities with an accredited nursing program, as defined in s. 464.003, F.S., that is located in and chartered by Florida and is licensed by the Commission for Independent Education pursuant to s. 1005.31, F.S. Additionally, the bill increases the passage rate for the Nursing License Examination, from 70 percent to 75 percent, that is required for LPN, associate of science in nursing, and bachelor of science in nursing programs to participate in LINE.

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;
- 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.

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

However, 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;
- 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.

Mobile Response Teams

The bill amends s. 394.455, F.S., to clarify that the terms "mobile crisis response service" and "mobile response teams" have the same meaning.

The bill amends s. 394.457, F.S., to require that the minimum standards for mobile crisis response services under Part I of ch. 394, F.S., include the standards of MRTs established under Part III of ch. 394, F.S., for children, adolescents, and young adults, as well as create a structure for general MRTs with a focus on emergency room diversion and the reduction of involuntary commitment that requires, but is not limited to:

- Triage and rapid crisis intervention within 60 minutes;
- Provision of and referral to evidence-based services that are responsive to the needs of the individual and family;
- Screening, assessment, early identification, care-coordination; and
- Follow-up at 90 and 180 days to gather outcome data on a mobile crisis response encounter to determine efficacy of the mobile crisis response service.

This aligns mobile crisis response service and MRT requirements under Parts I and III of ch. 394, F.S., and includes a follow up provision for these teams to better evaluate effectiveness.

The bill creates a non-statutory section of the Laws of Florida to require the AHCA to seek Medicaid coverage and reimbursement authority for crisis response services pursuant to 42 United States Code (U.S.C.) s. 1396w-6. The DCF must coordinate with the AHCA to educate contracted providers of child, adolescent, and young adult MRT services on the enrollment process as a Medicaid provider, encourage and incentivize enrollment as a Medicaid provider, and reduce barriers to maximize federal reimbursement for community-based mobile crisis response services.

Potentially Preventable Health Care Events

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.

Emergency Department Diversion for Medicaid Managed Care Plans

The bill amends s. 409.973, F.S., to ensure MMA plans assist new enrollees with initial primary care physician appointments until scheduled as a requirement of the plan's primary care initiative program.

The bill requires MMA plans to coordinate with a hospital that contacts the plan under the requirements of s. 395.1055(1)(j), F.S., for the purpose of establishing the appropriate delivery of primary care services for a plan's member who presents at the hospital's ED for nonemergent care or emergency care that could potentially have been avoided through the regular provision of primary care. The managed care plan must coordinate with the member and the member's primary care provider.

Acute Hospital Care at Home

The bill creates a non-statutory section of the Laws of Florida to require the AHCA to seek the federal approval necessary to implement a Florida Medicaid AHCAH program, consistent with the parameters specified in 42 United State Code s. 1395cc-7(a)(2)-(3).

Additional Path to Florida Licensure for Foreign-Trained Allopathic Physicians

The bill amends s. 458. 311, F.S., to create an additional education and training pathway to a Florida allopathic medical license for foreign trained physicians who have graduated from a foreign medical school that provides an educational program reasonably comparable to that of similarly accredited institutions in the U.S., and exempting them from the one year residency requirement, if the physician meets all of the following:

- Has an active, unencumbered license to practice medicine in a foreign country;
- Has actively practiced medicine in the four-year period preceding the date of the licensure application submission;
- Has completed a residency or substantially similar postgraduate medical training in a country recognized by his or her licensing jurisdiction;

- Has an offer for full-time employment as a physician from a health care provider that operates in this state.

The bill requires that a physician licensed under this pathway must maintain his or her employment with his or her original employer, or with another health care provider that also operates at a location within the state, for at least two consecutive years. Such licensed physicians must notify the BOM within five business days after any change of employer.

The bill also clarifies that all foreign medical school graduates seeking licenses in Florida, regardless of under what provision, must have graduated from a foreign medical schools that provides an educational program reasonably comparable to that of similarly accredited institutions in the U.S.

Restricted Allopathic Medical License

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.

Certification of Foreign Educational Institutions

The bill amends s. 458.314, F.S., to authorize the BOM, at its own discretion, to exclude any foreign medical school that fails to apply for certification under that section, from being considered as an institution that provides medical education that is reasonably comparable to similar accredited institutions in the U.S.

Medical Faculty Certificates for Allopathic Physicians

The bill amends s. 458.3145, F.S., to revise the criteria for issuing medical faculty certificates for medical doctors to:

- Exclude applicants who the BOM determines have not graduated from a medical school institution that provides medical education that is reasonably comparable to similar accredited institutions in the U.S ; and
- Deletes the cap on the maximum number of certificates that may be issued at specified institutions.

Temporary Certificates to Practice in Areas of Critical Need

The bill amends ss. 458.315 and 459.0076, F.S., to authorize the BOM and the BOOM to issue temporary certificates to allopathic and osteopathic physician assistants to practice in areas of critical need, under the same specified criteria as the statutes authorizes physicians to practice in those areas.

The bill creates s. 464.0121, F.S., which authorizes the BON to issue temporary certificates to APRNs who has a current valid license in any U.S. jurisdiction, and who meets the educational and training requirements established by the BON, to practice in areas of critical need. A temporary certificate may be issued to an APRN who will:

- 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 another agency or institution that is approved by the State Surgeon General and that provides health care services; or
- 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.

The bill authorizes the BON to issue a temporary APRN certificate to practice in areas of critical need as those areas are determined by the State Surgeon General, which may include, but are not limited to, health professional shortage areas designated by the U.S. Department of Health and Human Services.

The bill authorizes an APRN with a temporary certificate to practice in areas of critical need to use the certificate to work for any approved entity in any area of critical need authorized by the State Surgeon General; but require the APRN to notify the BON of all approved institutions in which the APRN practices within 30 days of accepting employment.

The bill requires the BON to review an application and issue one of the following within 60 days of receipt of an application for a temporary certificate:

- The temporary certificate;
- The denial of the application; or
- A notification to the applicant that the BON recommends additional assessment, training, education, or other requirements as a condition of issuing the temporary certification.

The bill authorizes the BON to administer an abbreviated oral examination to determine an APRN's competency, but may not require a regular, written examination. If the applicant has not actively practiced during the three years period immediately preceding the application, and the BON determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decision-making, the BON may:

- Deny the application;
- Issue a temporary certificate and impose 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 BON; or
- Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the BON, which may include, but are not limited to, completing CE or undergoing an assessment of skills and training.

The bill requires that an APRN's temporary certificate to practice in areas of critical need is only valid 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.

The bill required the BON to 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. If the BON determines that the certificateholder is not meeting

the minimum requirements, the BON must revoke the temporary certificate or impose restrictions or conditions, or both, as a condition of continued practice.

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 waves all licensure fees, and neurological injury compensation assessments, 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 APRN will not receive any compensation for any health care services that he or she provides.

Limited Licenses for Graduate Assistant Physicians

The bill amends ss. 458.317 and 459.0075, F.S.; to make conforming changes and create limited licenses for both allopathic and osteopathic graduate assistant physicians (GAPs). The BOM and the BOOM, respectively, must issue a GAP a limited 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 National Resident Match Program (NRMP) within the first year following graduation from medical school;
- Is at least 21 years of age;
- Is of good moral character;
- Has submits 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 as specified by the DOH.

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 GAP to apply for a one-time renewal for one additional year of his or her limited license provided he or she submits to the appropriate board documentation of:
- 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 a limited licensed GAP 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 GAPS with limited licenses;
- 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, and must ensure that:
  - There is a process for the evaluation of the limited licensed GAP's performance;
  - The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the GAP's level of competency;
  - The limited licensed GAP's prescriptive authority is governed by the physician-drafted protocol and may not exceed that of his or her supervising physician; and
  - Any prescriptions and orders issued by the GAP must identify both the GAP and the supervising physician.

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

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

Out-Of-Hospital Intrapartum Care Provided by Autonomous APRN Midwives

The bill amends s. 464.0123, F.S., to require an autonomous APRN certified nurse midwives, as a condition precedent to providing out-of-hospital intrapartum care, to have a written transfer policy for patients needing a higher acuity of care or emergency services, including an emergency plan-of-care form signed by the patient before admission which contains the following:
- 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.

The bill requires an autonomous APRN certified nurse midwives to document the following information on the patients emergency plan-of-care form if a transfer of care is determined to be necessary:

- The name, date of birth, and condition of the patient;
- The gravidity and parity of the patient and the gestational age and condition of the fetus or newborn infant;
- The reasons that necessitated the transfer of care;
- A description of the situation, relevant clinical background, assessment; and recommendations;
- The planned mode of transporting the patient to the receiving facility; and
- The expected time of arrival at the receiving facility.

The bill requires an autonomous APRN certified nurse midwives to 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 APRN certified nurse midwives 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 authorized 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 autonomous APRN certified nurse midwives engaged in autonomous practice; and eliminates the requirement that an autonomous APRN certified nurse midwife must have a written patient transfer agreement with a hospital and a written referral agreement with a physician to engage in nurse midwifery.

Multistate Compacts

The bill enacts the Interstate Medical Licensure Compact, Audiology and Speech-Language Pathology Interstate Compact, and Physical Therapy Compact, authorizing Florida to enter into the compacts. Below, the provisions of each compact that specifically relate the profession of the compact will be presented first and then those provisions that all three of the compacts have in common will be discussed.

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC) provides the framework under which party states must operate. The compact establishes the compact's administration and components and prescribe how the IMLC Commission will oversee the compact and conduct its business. Select provisions of the compact are discussed below.

The purpose of the compact is to provide a streamlined, comprehensive process that allows physicians to become licensed in multiple states. It allows physicians to become licensed without changing a state's medical practice act(s). The IMLC also adopts the prevailing standard of care based on where the patient is located at the time of the physician-patient encounter. Jurisdiction for disciplinary action or any other adverse actions against a physician's license is retained in the jurisdiction where the license is issued to the physician.

IMLC Eligibility

To receive a license under the IMLC, a physician must:

- 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 USMLE or the Commission on Osteopathic Medicine Licensing Exam (COMLEX-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 Specialties; however, the time-unlimited specialty certificate does not have to be maintained once the physician is initially determined eligible through the expedited Compact process;
- Possess a full and unrestricted license to engage in the practice of medicine issued by a member board;
- Have never been convicted or received adjudication, deferred 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.

IMLC Application and Issuance of Expedited Licensure

A physician must apply for expedited licensure through the Compact by filing an application with the member board in the physician's state of principal license (SPL). The SPL is the state in which the physician holds a full and unrestricted license to practice and is the physician's state of principal residence, where the physician performs 25 percent of his or her practice, or where the physician's employer is located. The member board must evaluate the application to determine whether the physician is eligible for the expedited licensure process and issue a letter of qualification, either verifying or denying eligibility, to the Commission.

The member board must verify static qualifications, which includes medical education, graduate medical educations, results of licensing examinations, and other qualifications as determined by the Commission by rule. Such static qualifications will not be subject to any other verification if they are verified by the SPL. The member board must also perform a criminal background check of the applicant, using fingerprints or other biometric data checks compliant with requirements of

the Federal Bureau of Investigations. The member state handles any appeals on eligibility determinations and such appeals are subject to the law of that state.

Upon completion of eligibility verification process with the member state, applicants suitable for an expedited license are directed to complete the registration process with the IMLC Commission. After completing the registration process, 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 in that state. 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 IMLC Commission to adopt rules regarding the application process, including the payment of any applicable fees and the issuance of an expedited license.

IMLC Renewal and Continued Participation

To renew a compact license the physician must:

- Maintain a full and unrestricted license in a SPL;
- Not have been convicted or 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.

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

IMLC Disciplinary Actions

Any disciplinary action taken by any member board against a physician licensed through the IMLC is deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the laws or regulations in that state.

If the physician’s license is revoked, surrendered, or relinquished in lieu of discipline in the SPL, or suspended, then all licenses issued to the physician under the IMLC are automatically placed in the same status without further action necessary by a member board. If the SPL subsequently reinstates the physician’s license, a license issued to the physician by any other member board remains encumbered until that respective board takes action to specifically reinstate the license in a manner consistent with the laws of that state.

If disciplinary action is taken against the physician in a member state that is not the SPL, other member states may deem the action conclusive as to matter of law and fact decided, and:

- Impose the same or lesser sanction or sanctions against the physician so long as such sanctions are consistent with the laws of that state;
- Pursue separate disciplinary action against the physician under its laws, regardless of the action taken in other member states; or
- Take no action.

If a license is revoked, surrendered, or relinquished in lieu of discipline, or suspended, then any license issued to the physician by any other member board is automatically suspended, without further action necessary by any other board for 90 days upon entry of the order by the disciplining board. During the 90-day suspension member board(s) may investigate the basis for the action under the laws of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the 90-day suspension period.

Additional Provisions Related to the Enactment of the IMLC

Under the bill, any physician licensed to practice medicine or osteopathic medicine under the Compact is deemed to be licensed under ch. 458 F.S., or ch. 459, F.S., respectively. The bill ensures that a Florida-licensed physician, licensed through the Compact, whose Florida license is suspended or revoked as result of licensure discipline by another state under the Compact, has the same administrative appeal rights under ch. 120, F.S., as any other Florida-licensed physician.

The bill provides that commissioners and any administrator, officer, executive director, employee, or representative of the Commission, when acting within the scope of their employment or responsibilities in this state are considered agents of the state, and requires the Commission to pay any claims or judgments that arise. The bill authorizes the Commission to maintain insurance coverage to pay any such claims or judgments.

Audiology and Speech-Language Pathology Interstate Compact

The bill authorizes Florida to enter the Audiology and Speech-Language Pathology Interstate Compact (ASLP Compact) by enacting the model language of the compact, which all member states must enact. The ASLP Compact model language establishes the compact's administration and prescribe how the ASLP Compact Commission oversees the compact and conduct its business. Select provisions of the ASLP Compact are discussed below.

ASLP Compact Purpose

The stated purpose of the ASLP Compact is to increase public access to audiology and speech-language pathology services.

ASLP Compact State Participation

The home state is a member state where an audiologist or speech-language pathologist is licensed to practice. The home state license must be recognized by each member state as authorizing an audiologist or speech-language pathologist to practice as such, under privileges to practice in each member state.

Each state must have a procedure to consider the criminal history of applicants for initial privileges to practice. The procedures must include submission of fingerprints or other biometric information to obtain the criminal history of an applicant from the Federal Bureau of Investigation (FBI) and the agency responsible for that state's criminal history records.

Communication between a member state, the ASLP Commission, and other member states regarding the eligibility for licensure may not include the criminal history record received from the FBI. When an application for compact privileges is submitted, the remote state shall verify through the data system, whether the applicant has ever held a license issued by any other state, whether there are any encumbrances on any license or privileges, and whether any adverse action has been taken against any license or privileges held by the applicant.

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 licensure renewal, as well as any other state laws.

To be eligible for compact privileges, an audiologist must:

- Meet one of the following educational requirements:
  - On or before December 31, 2007, have graduated with a master's or doctorate degree in audiology or an equivalent degree from an accredited program; or
  - On or after January 1, 2008, have graduated with a doctorate degree in audiology or an equivalent degree from an accredited program; or
  - Have graduated from an audiology program in a foreign institution of higher education for which the degree program and the 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 from an accredited educational institution or its cooperating programs.

To be eligible for compact privileges, a speech-language pathologist must:

- Meet one of the following educational requirements:
  - Have graduated with a master's degree from a speech-language pathology program from an accredited program; or
  - Have graduated from a speech-language pathology program in a foreign institution of higher education for which the degree program and the 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 from an accredited educational institution or its cooperating programs.
- Have completed a supervised postgraduate professional experience as required by the commission.

All applicants for compact privileges must:

- Have successfully passed a national examination approved by the commission.

- Hold an active, unencumbered license.
- Have 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.
- Have a valid United States social security number or National Provider Identifier number.

The privilege to practice under the ASLP Compact derives from the home state license. The practice of audiology and speech-language pathology is defined by the practice laws of the member state where the client is located, and an audiologist or speech-language pathologist practicing in that state must comply with those practice laws. While practicing under compact privileges in a member state, the audiologist and speech-language pathologist is subject to the jurisdiction of the licensing boards, courts, and laws of that state.

Individuals not residing in a member state may apply for a member state's single-state license. However, the single-state license may not be recognized as granting privileges to practice in any other member state. The compact does not affect the requirements established by each member state for the issuance of a single state license.

ASLP Compact Privileges

To exercise compact privileges, an audiologist or speech language pathologist must

- Hold an active license in the home state.
- Have no encumbrances on any state license.
- Be eligible for compact privileges in any member state, as provided above.
- Not have any adverse action against any license or compact privileges within the preceding two years.
- Notify the ASLP Compact Commission that he or she is seeking compact privileges within a remote state or states.
- Report to the commission any adverse action taken in a nonmember state within 30 days from the date the adverse action is taken.

An individual may only hold one home state license at a time. If an audiologist or speech-language pathologist changes his or her primary state of residence, he or she must apply for licensure in the new home state. The license issued by the prior home state must be deactivated. A license may not be issued in the new home state until the audiologist or speech-language pathologist provides satisfactory evidence of a change in the primary state of residence to the new home state and satisfies all applicable requirements for licensure in the new home state. If an audiologist or speech-language pathologist changes his or her primary state of residence to a nonmember state, the license issued by the prior home state becomes a single-state license, valid only in that state.

Compact privileges are valid until the expiration date of the home state license. A licensee practicing in a remote state under compact privileges must function within the laws and regulations of the remote state. A remote state may, in accordance with due process and state law, remove a licensee's compact privileges in that state for a specified time, impose fines, or take any other actions to protect the health and safety of its citizens.

If a home state license is encumbered, the licensee loses compact privileges in all remotes states until the home state license is no longer encumbered and two years have elapsed since the date of the adverse action. Once an encumbered home state license has been restored to good standing, the licensee must meet the requirements above to exercise compact privileges.

ASLP Compact Privileges to Practice Telehealth

Member states must recognize the right of an audiologist or speech-language pathologist, who is licensed in his or her own state in accordance with the compact, to practice audiology or speech-language pathology in any member state using telehealth under the compact privileges.

ASLP Compact Active Duty Military Personnel or Their Spouses

Active duty military personnel, or their spouse, must designate a home state where he or she has a current license in good standing. The individual may maintain this home state designation during any period of active duty. The home state may only be changed upon application for licensure in a new state.

ASLP Compact Adverse Action

A remote state may:

- Take adverse action against an audiologist's or speech-language pathologist's privileges to practice within the member state.
- Issue subpoenas for hearings and investigations, if necessary. Subpoenas issued by a member state for evidence or testimony 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. The issuing authority must pay any witness fees, travel expenses, mileage, or other fees required by the service statutes of the state in which the witness evidence is located.
- Complete any pending investigations of an audiologist or speech-language pathologist who changes his or her primary state of residence during an investigation. The home state may take appropriate actions and must promptly report the conclusions of the investigation to the commission's data system. The administrator of the data system must notify the new home state of any adverse actions.
- If permitted by state law, recover the costs of investigations and disposition of cases resulting from any adverse action taken from the affected audiologist or speech-language pathologist.
- Take adverse action based on the factual findings of a remote state, provided that the member state follows its own procedures for taking adverse action.

Only the home state may take adverse action against an individual's license issued by the home state. The home state must give the same priority and effect to reported conduct received from a member state as it would if the conduct occurred in the home state. The home state must apply its own state laws to determine the appropriate action.

Any member state may participate with other member states in joint investigations of licensees. Member states may share investigative, litigation, or compliance materials in furtherance of any joint or individual investigations initiated under the ASLP Compact.

If a home state takes adverse action against an audiologist's or speech-language pathologist's license, his or her privileges to practice in all other member states is deactivated until all encumbrances are removed. The disciplinary order imposing the adverse action must state that compact privileges are deactivated. If a member state takes adverse action, it must promptly notify the administrator of the data system, who must promptly notify the home state of the adverse action. The compact does not override a member's state decision to participate in an alternative program in lieu of adverse action.

Additional Provisions Related to the Enactment of the ASLP Compact

The bill requires the DOH to report any investigative information relating to an audiologist or speech-language pathologist holding compact privileges under the ASLP Compact to the compact's data system. In regards to participation in the impaired practitioner program, the bill requires that if the participant is an audiologist or speech-language pathologist practicing under the ASLP Compact, the terms of the monitoring contract must require withdrawal from all practice under the compact unless authorized by a member state.

The bill requires the Board of Speech-Language Pathology and Audiology to appoint two individuals to serve as the state's delegates on the ASLP Compact Commission. One appointee must be an audiologist and one appointee must be a speech-language pathologist. The bill provides that commissioners and any administrator, officer, executive director, employee, or representative of the ASLP Compact Commission, when acting within the scope of their employment or responsibilities in this state are considered agents of the state, and requires the commission to pay any claims or judgments that arise. The bill authorizes the commission to maintain insurance coverage to pay any such claims or judgments.

The bill exempts individuals holding compact privileges from complying with existing licensure by examination and licensure by endorsement requirements. The bill authorizes the board to take adverse action against an audiologist's or speech-language pathologist's compact privileges under the ASLP Compact and to impose any other applicable penalties if the practitioner subject to the compact commits an act that constitutes grounds for discipline under Florida law.

Physical Therapy Compact

The bill authorizes Florida to enter the Physical Therapy Licensure Compact (PT Compact) by enacting the model language of the compact, which all member states must enact. The PT Compact model language establishes the compact's administration and prescribe how the PT Compact Commission oversees the compact and conduct its business. Select provisions of the compact are described below.

PT Compact Purpose

The stated purposes and objectives of the PT Compact is to increase public access to physical therapy services by providing mutual recognition of member state licenses.

State Participation in the PT Compact

To participate in the PT Compact, a state must:

- Fully participate in the PT Compact Commission's data system.

- Have a mechanism in place for receiving and investigating complaints about a licensee.
- Notify the commission of any adverse action or the availability of investigative information regarding a licensee.
- Fully implement a criminal background check requirement, which uses results from an FBI criminal records search to make licensure decisions.
- Comply with the commission's rules.
- Use a recognized national examination as a requirement for licensure.
- Have continuing competence requirements as a condition of license renewal.

Member states must grant compact privileges to a licensee holding a valid, unencumbered license from another member state.

PT Compact Privileges

To exercise compact privileges, a licensee must:

- Hold a license in the home state.
- Have no encumbrances on any state license.
- Be eligible for compact privileges in all member state, as provided above.
- Not have had an adverse action against any license or compact privileges within the preceding two years.
- Notify the PT Compact Commission that he or she is seeking compact privileges within a remote state.
- Meet any jurisprudence requirements established by the remote state in which the licensee is seeking compact privileges.
- Report to the commission any adverse action taken in a nonmember state within 30 days from the date the adverse action is taken.

Compact privileges are valid until the expiration date of the home state license. A licensee practicing in a remote state under compact privileges must comply with the laws and rules of the remote state. A remote state may, in accordance with due process and state law, remove a licensee's compact privileges in the remote state for a specified time, impose fines, or take any other actions to protect the health and safety of its citizens. The licensee is not eligible for compact privileges in any member state until the specific period of time for removal has ended, all fines are paid, and two years have elapsed from the date of the adverse action.

If a home state license is encumbered, the licensee loses compact privileges in all remote states until the home state license is no longer encumbered and two years have elapsed since the date of the adverse action. Once an encumbered home state license has been restored to good standing, the licensee must meet the requirements above to exercise compact privileges.

Active Duty Military Personnel and Their Spouses

For active duty military personnel or the spouse of an individual who is active duty military, one of the following may be designated as his or her home state:

- Home of record;
- Permanent change of station location; or

- State of current residence, if it is different from the home of record or permanent change of station location.

Adverse Action

The home state has exclusive power to impose adverse action against a license issued by that state. The home state may take adverse action based on investigation information received from a remote state, in accordance with its own procedures for imposing adverse action. The PT Compact does not override a member's state decision to participate in an alternative program in lieu of adverse action.

A member state may investigate actual or alleged violations of law and rules for the practice of physical therapy committed in any other member state by a physical therapist or physical therapist assistant who holds a license or compact privileges in such other member state.

A remote state may:

- Take adverse action against a licensee's compact privileges in the state.
- Issue subpoenas for hearings and investigations, if necessary. Subpoenas issued by a member state for evidence or testimony 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. The issuing authority must pay any witness fees, travel expenses, mileage, or other fees required by the service laws of the state in which the witness evidence is located.
- Complete any pending investigations of an audiologist or speech-language pathologist who changes his or her primary state of residence during an investigation. The home state may take appropriate actions and must promptly report the conclusions of the investigation to the commission's data system. The administrator of the data system must notify the new home state of any adverse actions.
- If permitted by state law, recover the costs of investigations and disposition of cases resulting from any adverse action taken from the licensee.

Any member state may participate with other member states in joint investigations of licensees. Member states must share investigative, litigation, or compliance materials in furtherance of any joint or individual investigations initiated under the PT Compact.

Additional Provisions Related to the Enactment of the PT Compact

The bill requires the DOH to report any investigative information relating to a physical therapist or physical therapist assistant holding compact privileges under the PT Compact to the compact's data system. In regards to participation in the impaired practitioner program, the bill requires that if the participant is a physical therapist or physical therapist assistant practicing under the PT Compact, the terms of the monitoring contract must require withdrawal from all practice under the compact unless authorized by a member state.

The bill requires the board of physical therapy practice to appoint an individual to serve as the state's delegate on the PT Compact Commission. The bill provides that commissioners and any administrator, officer, executive director, employee, or representative of the PT Compact Commission, when acting within the scope of their employment or responsibilities in this state are considered agents of the state, and requires the commission to pay any claims or judgments

that arise. The bill authorizes the commission to maintain insurance coverage to pay any such claims or judgments.

The bill exempts individuals holding compact privileges from complying with existing licensure by examination or licensure by endorsement requirements.

The bill authorizes the board to take adverse action against a physical therapist's or physical therapist assistant's compact privileges under the PT Compact and to impose any other applicable penalties if a practitioner subject to the PT Compact commits an act that constitutes grounds for discipline under Florida law.

Provisions Common to the IMLC, ASLP Compact, and PT Compact

Coordinated Data System

Each of the compacts require the establishment and maintenance of a coordinated database and reporting system containing licensure, adverse actions, and investigative information on all licensed individuals in participating states.

Compact Commission

Each of the compacts also establish a compact commission that has duties, powers, and responsibilities under the respective compacts. Generally, each member state's licensure board selects one individual (PT Compact) or two individuals (IMLC and ASLP Compact) to represent the state on the commission. Each commissioner is entitled to one vote. Each compact's must meet at least once per year, although additional meetings may be held in accordance with the bylaws or rules of the respective commission. The meetings of the commissions must be noticed and open to the public, except that meetings may be closed when discussing certain sensitive information or privileged communication.

The commissions are empowered to perform functions that may be necessary to achieve the purpose of the respective compacts. The may perform functions such as borrow money, accept donations, adopt rules, perform fiscal management duties, and bring and prosecute legal proceedings.

Each of the commissions must keep minutes that describe all the matters discussed in a meeting and provide a full and accurate summary of action taken. Such information and official records, to the extent, not otherwise designated in the compact or by its rules, must be made available to the public for inspection.

All three commissions require the establishment of an executive committee that has the power to act on behalf of the respective commissions, as provided in each of the compact's bylaws.

All three compacts provide immunity to and limits the liability of its officers and employees from suit and liability, either personally or in their professional capacity, for a claim for damage to or loss of property or personal injury or other civil liability cause or arising out of, or relating to, an actual or alleged act, error or omission that occurred with the scope of commission employment, duties, or responsibilities. Such person is not protected from suit or liability for

damage or loss, injury or liability caused by the intentional or willful and wanton conduct of such a person.

The compacts will indemnify their executive directors and its employees, subject to the approval of the state's attorney general or other appropriate legal counsel, in any civil action seeking to impose liability arising out of the performance of duties within such person's scope of employment. To the extent not covered by the state involved, the employees and representatives are held harmless in the amount of any settlement or judgement, arising out of out of the performance of duties within such person's scope of employment and not a result of intentional or willful and wanton misconduct.

Rulemaking Functions

Each compact authorizes its commissions to promulgate rules and sets forth requirements for notice, hearings, rule amendments, and emergency rule-making. Generally, rules and amendments become binding as of the date specified in each rule or amendment and must be adopted at a regular or special meeting of the respective commission. The ASLP Compact and PT Compact provide that if a majority of the legislatures of member states reject a rule by enactment of a statute or resolution in the same manner used to adopt the compact within four years after the rule is adopted, the rule does not have further force and effect in any compact state.

Oversight of Interstate Compact

Each compact requires member state's executive, legislative, and judicial branches to enforce the respective compacts, and take necessary action to effectuate each compact's purpose and intent. The provisions of the each compact and the rules adopted thereunder have standing as statutory law to the extent that it does not override the state's authority to regulate its practitioners.

All courts are to take judicial notice of the compacts and any adopted administrative rules in a proceeding involving compact subject matter. Each compact's commission is entitled to receive service of process and have standing in any proceeding. Failure to serve the appropriate commission renders a judgment null and void as to the Commission, the respective compact, or promulgated rule.

Default Procedures

Generally, if a commission determines that a member state has defaulted on its obligations, the commission must:

- Provide written notice to the defaulting state and all member states the nature of the of the default, the means of and conditions for curing the default, and any action taken by the commission; and
- Provide remedial training and specific technical assistance regarding the default.

If the defaulting state fails to cure the default, a commission must terminate the state from the respective compact after all other means of securing compliance are exhausted. A cure of the default does not relieve a defaulting state of its obligations under the compact. The affected

commission must notify the governor, the majority and minority leaders of the defaulting state's legislature, and each member state of its intent to terminate.

A terminated state remains liable for all dues, obligations, and liabilities incurred through the effective date of the termination. The compacts provide an appeal process for the terminating state and procedures for attorney's fees and costs.

Dispute Resolution

Generally, the compacts require their commissions to use dispute resolution tools to resolve disputes between states, such as mediation and binding dispute resolution.

Withdrawal and Dissolution

A member state may withdraw from a compact by repealing the law which enacted the compact into that state's law. A repeal IMLC may not take effect for at least one year after the effective date of such action and a repeal of the ASLP Compact or the PT Compact may not take effect for at least six months after the effective date. Written notice must be given by the withdrawing state to the other member states.

The withdrawing state must immediately notify the appropriate commission, in writing, upon the introduction of legislation to repeal the compact. The commission of that compact must notify the other member states of the withdrawing state's notification of the introduction of legislation repealing that state's participation in the compact. The withdrawing state remains responsible for any dues, obligations, or liabilities incurred through the date of withdrawal. A state may be reinstated upon reenactment of the compact.

Dissolution

Each compact provides that the compact shall be dissolved when the membership of the compact is reduced to one. Once dissolved, the compact is null and any surplus funds of the commission shall be distributed in accordance with the bylaws.

Severability and Construction

The provisions of the compacts are severable, and if any part of the compacts is not enforceable, the remaining provisions are still enforceable. The provisions of the compacts are to be liberally construed, and not construed to prohibit the applicability of other interstate compacts to which member states may be members.

Binding Effect of Compact and Other Laws

None of the compacts prohibit the enforcement of other laws which are not in conflict with its language. The compacts supersedes any conflicting law of a member state to the extent of the conflict. If a compact conflicts with a member state's constitution, the conflicting compact provision is ineffective in that member state.

The actions of the compact commissions are binding on the member states, including all promulgated rules and the adopted bylaws of the commissions. All agreements between a Commission and a member state are binding in accordance with their terms.

The bill makes conforming changes to Florida Statutes related to enacting the three compacts.

Appropriations

The bill makes a number of appropriations of general revenue and trust fund dollars. See Section V. of this analysis under "Government Sector Impact."

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

The IMLC Commission, ASPL Compact Commission, and the PT Compact Commission are required to have most of their meetings be open to the public. The public must also be provided a reasonable opportunity to provide public comment, orally or in writing, for proposed rules.

All three compacts permit their commissions to meet in closed, nonpublic meetings under certain circumstances or to discuss certain topics. Under the compacts, 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.

The rulemaking process, its timelines and public involvement in the process, plus the closure of public meetings, may be inconsistent with Florida law on public records and public meetings.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

The multistate compacts enacted in Florida under 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 the 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.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

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.

C. Government Sector Impact:

The bill may create additional workload demands for the DOH and the AHCA to administer their duties created under the bill.

SPB 7016 provides the following appropriations for the 2024-2025 state fiscal year:

- The sum of $50 million in recurring funds from the General Revenue Fund is appropriated to the DOH for FRAME.
- The sum of $13.2 million in recurring 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 $40 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 $29,428,000 in recurring funds from the General Revenue Fund and $40,572,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA for the Slots for Doctors Program.
- The sums of $42,040,000 in recurring funds from the Grants and Donations Trust Fund and $57,960,000 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 $64,030,325 in recurring funds from the General Revenue Fund and $88,277,774 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 $82,301,239 in recurring funds from the General Revenue Fund and $113,467,645 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 $195,768,884 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 $10 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.
- The sum of $2.4 million in recurring funds from the General Revenue Fund is appropriated to the Agency for Health Care Administration for the purpose of providing behavioral health family navigators in state-licensed specialty hospitals providing comprehensive acute care services to children pursuant to s. 395.002(28), F.S., to help facilitate early access to mental health treatment. Each licensed specialty hospital will receive $600,000 from this appropriation.
- Effective October 1, 2024, the sums of $14,682,841 in recurring funds from the General Revenue Fund and $20,243,041 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. 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 $12,067,327 in recurring funds from the General Revenue Fund, $127,300 in recurring funds from the Refugee Assistance Trust Fund, and $16,812,576 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 $14,378,863 in recurring funds from the General Revenue Fund and $19,823,951 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 $9,532,569 in recurring funds from the General Revenue Fund and $13,142,429 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.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.4018, 381.4019, 383.2163, 383.302, 383.309, 383.313, 383.315, 383.316, 383.318, 394.455, 394.457, 394.4598, 394.4615, 394.4625, 394.463, 394.4655, 394.467, 394.4781, 394.4785, 394.875, 395.1055, 395.602, 408.051, 409.909, 409.967, 409.973, 456.073, 456.076, 458.311, 458.313, 458.314, 458.3145, 458.315, 458.316, 458.3165, 458.317, 459.0075, 459.0076, 464.0123, 464.019, 468.1135, 468.1185, 468.1295, 486.023, 486.025, 486.028, 486.031, 486.0715, 486.081, 486.102, 486.1065, 486.107, 486.125, 766.1115, 768.28, 1002.32, and 1009.8962.

This bill creates the following sections of the Florida Statutes: 381.4021, 381.9855, 383.3081, 383.3131, 409.91256, 456.4501, 456.4502, 456.4504, 458.3129, 459.074, 464.0121, 468.1335, and 486.112.

This bill transfers, renumbers, and amends the following sections of the Florida Statutes: 1009.65 to 381.402.

This bill creates several non-statutory sections of Florida law.

This bill repeals section 458.3124 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

268962

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
12/12/2023	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment (with title amendment)

Between lines 3154 and 3155

insert:

Section 52. 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:

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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 the 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) "Conviction" 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 which 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 or 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

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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 of the compact.

(2) A physician who does not meet the requirements specified 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;

(b) The state where at least 25 percent of the physician's practice of medicine occurs;

(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 physician's

state of residence for purpose of federal income tax.

(2) A physician may redesignate a member state as 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

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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 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).

(4) After receiving verification of eligibility under subsection (2) and upon an applicant's completion of any registration process 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 license for a nondisciplinary reason, without redesignation of a new state of principal license.

(7) The Interstate Commission may develop rules regarding the application process and the issuance of an expedited license.

SECTION 6

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) Physician information collected by the Interstate Commission during the renewal process must be distributed to all member boards.


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(4) The Interstate Commission may develop rules to address renewal of licenses obtained through the compact.

SECTION 7
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).

(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.

(7) The Interstate Commission may develop rules for mandated or discretionary sharing of information by member boards.


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SECTION 8

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 9

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 license issued to the physician by any other member board must be suspended, automatically and immediately without further action necessary by the 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 90-day suspension period in a manner consistent with the medical practice act of that state.

SECTION 10

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.

(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).

(8) 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;


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(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, the 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 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 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 and its bylaws and rules, and other duties as necessary.

(12) The Interstate Commission may establish other committees for governance and administration of the compact.

SECTION 11
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 and 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 11, 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 the power 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 them 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 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 12

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 before 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 13

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 over 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. Nothing in this subsection may be construed to 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 14

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

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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 may not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 15

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 shall have standing as statutory law but do 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 16

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 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 17

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 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 fees.

SECTION 18

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.

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SECTION 19

MEMBER STATES, EFFECTIVE DATE, AND AMENDMENT

(1) Any state is eligible to become a member state of the compact.

(2) The compact becomes effective and binding upon legislative enactment of the compact into law by no less than seven 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. No amendment becomes 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 20

WITHDRAWAL

(1) Once effective, the compact shall continue in force and remain binding upon each 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

shall not take effect until 1 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 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 21

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, 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 22
SEVERABILITY AND CONSTRUCTION

(1) The provisions of the compact are 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 may be construed to prohibit the applicability of other interstate compacts to which the states are members.

SECTION 23
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 53. 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

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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 54. 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 55. 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 56. 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 57. Paragraph (j) is added to subsection (10) of section 768.28, Florida Statutes, 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;

852 exclusions; indemnification; risk management programs.—
853 (10)
854 (j) For purposes of this section, the representative
855 appointed from the Board of Medicine and the representative
856 appointed from the Board of Osteopathic Medicine, when serving
857 as commissioners of the Interstate Medical Licensure Compact
858 Commission pursuant to s. 456.4501, and any administrator,
859 officer, executive director, employee, or representative of the
860 Interstate Medical Licensure Compact Commission, when acting
861 within the scope of their employment, duties, or
862 responsibilities in this state, are considered agents of the
863 state. The commission shall pay any claims or judgments pursuant
864 to this section and may maintain insurance coverage to pay any
865 such claims or judgments.
866
867 ================ T I T L E A M E N D M E N T ================
868 And the title is amended as follows:
869 Delete line 341
870 and insert:
871 act; creating s. 456.4501, F.S.; enacting the
872 Interstate Medical Licensure Compact in this state;
873 providing purposes of the compact; providing that
874 state medical boards of member states retain
875 jurisdiction to impose adverse action against licenses
876 issued under the compact; defining terms; specifying
877 eligibility requirements for physicians seeking an
878 expedited license under the compact; providing
879 requirements for designation of a state of principal
880 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

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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 to implement the compact; creating ss. 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. 768.28, F.S.; designating the state commissioners of the Interstate Medical Licensure Compact Commission and other members or employees of the 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; providing appropriations; providing effective

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LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
12/12/2023	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 3154 and 3155

insert:

Section 52. Section 468.1335, Florida Statutes, is created to read:

468.1335 Audiology and Speech-Language Pathology Interstate Compact.—The 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

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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 the 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.

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(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 which 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-

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language pathology by the licensee and the adverse action has been reported to the National Practitioner Data Bank.

(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 which 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 which has the force of law.

(22) "Single-state license" means an audiology or speech-language pathology license issued by a member state which 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 which 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 which 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-

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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

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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;

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

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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.

(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.

(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 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.

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(f) 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 hold only 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

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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 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 the conclusions of the investigations to the administrator of the data system. 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.

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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) The 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.

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(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 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

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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.

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(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 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.

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,

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and services.

(c) 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.

(d) 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 may not be construed to 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


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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

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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

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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 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

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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 as 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

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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 which does not conflict with 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 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 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 be affected. If the compact is held contrary to the constitution of any member state, it 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) This compact does not prevent the enforcement of any other law of a member state which 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 53. 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 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

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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 54. 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.

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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 an audiologist or a speech-language pathologist practicing under the Audiology and Speech-Language Pathology Interstate Compact pursuant to s. 468.1335, 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 unless authorized by a member state. ~~If the impaired practitioner is a 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.~~

Section 55. Present subsections (4), (5), and (6) of section 468.1135, Florida Statutes, are redesignated 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, as required under s. 468.1335, one of whom must be an audiologist and one of whom must be a speech-language pathologist.

Section 56. Subsection (6) is added to section 468.1185,

Florida Statutes, to read:

468.1185 Licensure.—

(6) 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.

Section 57. 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

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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

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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 58. Paragraph (j) is added to subsection (10) of section 768.28, Florida Statutes, 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 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 pursuant to 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 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.

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

And the title is amended as follows:

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Delete line 341

and insert:

act; creating s. 468.1335, F.S.; creating the Audiology and Speech-Language Pathology Interstate Compact; providing purposes and objectives; defining terms; 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 a compact privilege; providing for the expiration and renewal of the compact privilege; specifying that a licensee with a 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 licensees must adhere to the laws and rules of the remote state where they provide

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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 individuals may subsequently change their 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; providing construction and for severability; specifying that the compact, commission rules, and commission actions are binding on member states; amending s. 456.073, F.S.; requiring the Department of Health to report certain investigative information to the commission's data system; amending s. 456.076, F.S.; requiring that monitoring contracts


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for certain impaired practitioners participating in treatment programs contain specified terms; 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.; exempting audiologists and speech-language pathologists from licensure requirements if they 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; amending s. 768.28, F.S.; designating the state delegates and other members or employees of the 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 compact commission to maintain insurance coverage to pay such claims or judgments; providing appropriations; providing effective

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LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
12/12/2023	.	
	.	
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	.	

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

Senate Amendment (with title amendment)

Between lines 3154 and 3155
insert:

Section 52. 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:

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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


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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

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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.

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(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,

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which uses results from the Federal Bureau of Investigation record search on criminal background checks to make licensure decisions in accordance with subsection (2).

(e) Comply with the commission's rules.

(f) Use a recognized national examination as a requirement for licensure pursuant to the commission's rules.

(g) Have continuing competence requirements as a condition for license renewal.

(2) Upon adoption of the compact, a member state has the authority to obtain biometric-based information from each licensee applying for a compact privilege and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. s. 534 and 34 U.S.C. s. 40316.

(3) A member state must grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise the compact privilege under the compact, a licensee must satisfy all of the following conditions:

(a) Hold a license in the home state.

(b) Not have an encumbrance on any state license.

(c) Be eligible for a compact privilege in all member states in accordance with subsections (4), (7), and (8).

(d) Not have had an adverse action against any license or compact privilege within the preceding 2 years.

(e) Notify the commission that the licensee is seeking the

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compact privilege within a remote state.

(f) Meet any jurisprudence requirements established by the remote state in which the licensee is seeking a compact privilege.

(g) Report to the commission adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) The compact privilege is valid until the expiration date of the home license. The licensee must continue to meet the requirements of subsection (1) to maintain the compact privilege in a remote state.

(3) A licensee providing physical therapy in a remote state under the compact privilege must comply with the laws and rules of the remote state.

(4) A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any member state until the specific period of time for removal has ended and all fines are paid.

(5) If a home state license is encumbered, the licensee loses the compact privilege in any remote state until the following conditions are met:

(a) The home state license is no longer encumbered.

(b) Two years have elapsed from the date of the adverse action.

(6) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in any remote state.

(7) If a licensee's compact privilege in any remote state is removed, the licensee loses the compact privilege in all remote states until all of the following conditions are met:

(a) The specific period of time for which the compact privilege was removed has ended.

(b) All fines have been paid.

(c) Two years have elapsed from the date of the adverse action.

(8) Once the requirements of subsection (7) have been met, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in a remote state.

ARTICLE V

ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may choose any of the following locations to designate his or her home state:

(1) Home of record.

(2) Permanent change of station location.

(3) State of current residence, if it is different from the home of record or permanent change of station location.

ARTICLE VI

ADVERSE ACTIONS

(1) A home state has exclusive power to impose adverse

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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

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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 may 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


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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

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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

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designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(i) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action must be identified in the minutes. All minutes and documents of a closed meeting must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(3) DUTIES.—The commission shall do all of the following:

(a) Establish the fiscal year of the commission.

(b) Establish bylaws.

(c) Maintain its financial records in accordance with the bylaws.

(d) Meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(4) POWERS.—The commission may do any of the following:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules have the force and effect of law and are binding in all member states.

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law is not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel,

including, but not limited to, employees of a member state.

(e) Hire employees and elect or appoint officers; fix the compensation of, define the duties of, and grant appropriate authority to such individuals to carry out the purposes of the compact; and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(f) Accept any appropriate donations and grants of money, equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(g) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(h) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(i) Establish a budget and make expenditures.

(j) Borrow money.

(k) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in the compact and the bylaws.

(l) Provide information to, receive information from, and cooperate with law enforcement agencies.

(m) Establish and elect an executive board.


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(n) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of physical therapy licensure and practice.

(5) THE EXECUTIVE BOARD.—

(a) The executive board may act on behalf of the commission according to the terms of the compact.

(b) The executive board shall be composed of the following nine members:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. One ex-officio, nonvoting member from the recognized national physical therapy professional association.

3. One ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

(c) The ex-officio members shall be selected by their respective organizations.

(d) The commission may remove any member of the executive board as provided in its bylaws.

(e) The executive board shall meet at least annually.

(f) The executive board shall do all of the following:

1. Recommend to the entire commission changes to the rules or bylaws, compact legislation, fees paid by compact member states, such as annual dues, and any commission compact fee charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractually or otherwise.

3. Prepare and recommend the budget.

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4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Perform other duties as provided in the rules or bylaws.

(6) FINANCING OF THE COMMISSION.—

(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The commission may accept any appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) The commission may levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must total to an amount sufficient to cover the commission's annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based upon a formula to be determined by the commission, which shall adopt a rule binding upon all member states.

(d) The commission may not incur obligations of any kind before securing the funds adequate to meet such obligations; nor may the commission pledge the credit of any of the member states, except by and with the authority of the member state.

(e) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission are subject to the audit and accounting

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procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION.—

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, whether personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, this paragraph may not be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection may not be construed to prohibit any member, officer, executive director, employee, or representative of the commission from retaining his or her own counsel or to

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require the commission to defend such person if the actual or alleged act, error, or omission resulted from that person's intentional, willful, or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states.

(2) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission, which data set must include all of the following:

(a) Identifying information.

(b) Licensure data.

(c) Investigative information.

(d) Adverse actions against a license or compact privilege.

(e) Nonconfidential information related to alternative program participation.

(f) Any denial of application for licensure and the reason for such denial.

(g) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Investigative information in the system pertaining to a licensee in any member state must be available only to other 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

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the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, such rule does not have further force and effect in any member state.

(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule by the commission, and at least 30 days before the meeting at which the rule will be considered and voted upon, the commission must file a notice of proposed rulemaking on all of the following:

(a) The website of the commission or another publicly accessible platform.

(b) The website of each member state physical therapy licensing board or another publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed date, time, and location of the meeting in which the rule or amendment will be considered and voted upon.

(b) The text of the proposed rule or amendment and the reason for the proposed rule.

(c) A request for comments on the proposed rule or amendment from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.


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(6) Before adoption of a proposed rule or amendment, the commission must allow persons to submit written data, facts, opinions, and arguments, which must be made available to the public.

(7) The commission must grant an opportunity for a public hearing before it adopts a rule or an amendment if a hearing is requested by any of the following:

(a) At least 25 persons.

(b) A state or federal governmental subdivision or agency.

(c) An association having at least 25 members.

(8) If a scheduled public hearing is held on the proposed rule or amendment, the commission must publish the date, time, and location of the hearing. If the hearing is held through electronic means, the commission must publish the mechanism for access to the electronic hearing.

(a) All persons wishing to be heard at the hearing must notify the executive director of the commission or another designated member in writing of their desire to appear and testify at the hearing at least 5 business days before the scheduled date of the hearing.

(b) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(c) All hearings must be recorded. A copy of the recording must be made available on request.

(d) This article may not be construed to require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this section.

(9) Following the scheduled hearing date, or by the close

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of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(10) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public hearing.

(11) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this article are retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to do any of the following:

(a) Meet an imminent threat to public health, safety, or welfare.

(b) Prevent a loss of commission or member state funds.

(c) Meet a deadline for the adoption of an administrative rule established by federal law or rule.

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors,

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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

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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

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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

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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


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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 53. Subsection (10) of section 456.073, Florida


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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 a physical therapist or physical therapist assistant holding a compact privilege under the Physical Therapy Licensure Compact to the data system pursuant to s. 486.112; 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

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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 54. 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.

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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 unless authorized by a member state. ~~If the impaired practitioner is a 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.~~

Section 55. Subsection (5) is added to section 486.023, Florida Statutes, to read:

486.023 Board of Physical Therapy Practice.—

(5) The board shall appoint an individual to serve as the state's delegate on the Physical Therapy Compact Commission, as required under s. 486.112.

Section 56. 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

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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 57. 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

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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 58. Section 486.081, Florida Statutes, is amended to read:

486.081 Physical therapist; issuance of license without examination to person passing examination of another authorized examining board; fee; exemption.—

(1) The board may grant ~~cause~~ a license without examination, to be issued by ~~through~~ the department, ~~without examination~~ to any applicant who presents evidence satisfactory to the board of having passed the American Registry Examination before ~~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 under ~~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

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"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 filing an ~~making~~ application for licensure without examination under ~~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 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 59. 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

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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

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Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 60. Section 486.107, Florida Statutes, is amended to read:

486.107 Physical therapist assistant; issuance of license without examination to person licensed in another jurisdiction; fee; exemption.—

(1) The board may grant ~~cause~~ a license without examination, to be issued by ~~through~~ the department, ~~without examination~~ to any applicant who presents evidence to the board, under oath, of 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 applicable ~~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 under ~~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 without examination under ~~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

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scope provided therein, is exempt from the licensure requirements of this section.

Section 61. 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.

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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

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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

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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 62. Paragraph (j) is added to subsection (10) of section 768.28, Florida Statutes, 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 individual appointed under s. 486.023(5) as the state's delegate on the Physical Therapy Compact Commission, when serving in that capacity pursuant to 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

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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.

Section 63. 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 64. 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),

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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 65. 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.

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

And the title is amended as follows:

Delete line 341

and insert:

act; creating s. 486.112, F.S.; creating the Physical Therapy Licensure Compact; providing a purpose and objectives of the compact; defining terms; 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

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to licensees if they 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

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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

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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; 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 monitoring contracts for certain impaired practitioners participating in treatment programs to contain specified terms; amending s. 486.023, F.S.; requiring the Board of Physical Therapy Practice to appoint an individual to serve as the state's delegate on the Physical Therapy Compact Commission; amending ss. 486.028, 486.031, 486.081, 486.102, and 486.107, F.S.; exempting physical therapists and physical therapist assistants from licensure requirements if they are practicing in this state pursuant to a compact privilege under the compact; 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. 768.28, F.S.; designating the state delegate and other members or

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employees of the 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 ss. 486.025, 486.0715, and 486.1065, F.S.; conforming cross-references; providing appropriations; providing effective

FOR CONSIDERATION By the Committee on Health Policy

588-01750B-24 20247016pb

A bill to be entitled

An act relating to health care; 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 are not eligible to receive funds under the program unless they 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; making conforming and technical changes; requiring practitioners who receive payments under the program to furnish certain information requested by the department; requiring the

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agency to seek federal authority to use specified matching funds for the program; providing for future repeal of the program; creating s. 381.4021, F.S.; requiring the department to provide annual reports to the Governor and the Legislature 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 begin collecting data for the study and submit the study results to the Governor and the Legislature by specified dates; 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 or services 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 annual reports to the Governor and the Legislature; providing requirements for the reports; amending s. 383.302, F.S.; defining the terms "advanced birth center" and "medical director"; revising the definition of the term "consultant"; creating s. 383.3081, F.S.; providing requirements for birth centers designated as advanced birth centers with respect to operating procedures, staffing, and equipment; requiring advanced birth centers 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; amending s. 383.313, F.S.; making technical and conforming changes; 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; 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; making a conforming change; 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; providing an exception; 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 specified date, 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 process for hospitals to share certain information with certain patients' managed care plans; 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; defining the term "sponsoring institution"; requiring such hospitals and qualifying institutions, beginning on a specified date, 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 their 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 an annual report to the Governor and the Legislature 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; defining terms; 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 an annual report to the Governor and the Legislature; 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 specified dates; 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 a specified annual report on patient encounter data under the statewide managed care program; providing requirements for the report; requiring the agency to submit the report to the Governor and the Legislature by a specified date; 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; amending s. 458.311, F.S.; revising an education and training requirement for physician licensure; exempting foreign-trained applicants for physician licensure from the residency requirement if they meet specified criteria; 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. 458.314, 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; making conforming and technical changes; 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; 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 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. 1002.32, F.S.; requiring developmental research (laboratory) schools (lab schools) to develop programs for a specified purpose; requiring lab schools to offer technical assistance to any school district seeking to replicate the lab school's programs; requiring lab schools, beginning on a specified date, to annually report to the Legislature on the development of such programs and their results; amending s. 1009.8962, F.S.; revising the definition of the term "institution" for purposes of the Linking Industry to Nursing Education (LINE) Fund; amending ss. 381.4018, 395.602, 458.313, 458.316, and 458.3165, F.S.; conforming provisions to changes made by the act; providing appropriations; providing effective dates.

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

Section 1. 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) "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; and

(b) Volunteer 25 hours per year providing dental services in a free clinic that is located in a dental health professional shortage area or a medically underserved area 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 applied 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.

~~(c) 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 ~~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) 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 2. Section 1009.65, Florida Statutes, is transferred, 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 with primary care specialties.~~,~~

(b) Doctors of osteopathic medicine with primary care specialties.

(c) Advanced practice registered nurses registered to engage in autonomous practice under s. 464.0123 and practicing in a primary care specialty.~~, physician assistants, licensed practical nurses and registered nurses, and~~

(d) Advanced practice registered nurses with primary care specialties ~~such as certified nurse midwives~~.

(e) Physician assistants.

(f) Mental health professionals, including licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists.

(g) 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 which may be identified by the Department of Health.

(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 an area 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 and physician assistants, up to $75,000 for mental health professionals, and up to $45,000 ~~$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 3. Section 381.4021, Florida Statutes, is created to read:

381.4021 Student loan repayment programs reporting.—

(1) For the student loan repayment programs established in ss. 381.4019 and 381.402, the department shall annually provide a report, beginning July 1, 2024, to the Governor, the President of the Senate, and the Speaker of the House of Representatives 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 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.

(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 4. 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 criteria an applicant must meet to be eligible.

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 new health care screening or services programs 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 new locations 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 licensed health care practitioners to opportunities for volunteering their 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 need not be 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 5. 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) REPORTS.—By October 31, 2025, and each October 31 thereafter, the department shall submit a program report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which 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 ethnicity and race, age, education levels, 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.

(l) For the initial report, all available quantifiable data related to the telehealth minority maternity care pilot programs.

(6) 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 6. Present subsections (1) through (8), (9), and (10) of section 383.302, Florida Statutes, are redesignated as subsections (2) through (9), (11), and (12), respectively, new subsections (1) and (10) are added to that section, and present subsection (4) of that section is amended, 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 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 7. 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 8. Section 383.309, Florida Statutes, is amended to read:

383.309 Minimum standards for birth centers and advanced birth centers; rules and enforcement.—

(1) The agency shall adopt and enforce rules to administer ss. 383.30-383.332 and part II of chapter 408, which rules shall include, but are not limited to, reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and

occupational disciplines are available at all times to provide necessary and adequate patient care and safety.

(b) Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented.

(c) Licensed facilities are established, organized, and operated consistent with established programmatic standards.

(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.

(3) The agency may not establish any rule governing the design, construction, erection, alteration, modification, repair, or demolition of birth centers. It is the intent of the Legislature to preempt that function to the Florida Building Commission and the State Fire Marshal through adoption and maintenance of the Florida Building Code and the Florida Fire Prevention Code. However, the agency shall provide technical assistance to the commission and the State Fire Marshal in updating the construction standards of the Florida Building Code and the Florida Fire Prevention Code which govern birth centers. In addition, the agency may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code which apply to birth centers in conducting any inspection authorized under this chapter or part II of chapter 408.

Section 9. 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 10. 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 11. 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 on call 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 12. 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) 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 13. Present subsections (2) and (3) of section 383.318, Florida Statutes, are redesignated as subsections (3) and (4), respectively, a new subsection (2) is added to that section, and subsection (1) of that section is amended, to read:

383.318 Postpartum care for birth center clients and infants.—

(1) Except at advanced birth centers 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 of the infant 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 14. 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 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 15. Paragraph (c) of subsection (5) of section 394.457, Florida Statutes, is amended to read:

394.457 Operation and administration.—

(5) RULES.—

(c) The department shall adopt rules establishing minimum standards for services provided by a mental health overlay program or a mobile crisis response service. Minimum standards for a mobile crisis response service must:

1. Include the requirements of the child, adolescent, and young adult mobile response teams established under s. 394.495(7) and ensure coverage of all counties by these specified teams; and

2. 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; and

d. Follow-up 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 16. 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 17. 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 18. 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, a clinical psychologist with at least 3 years of clinical experience, or a psychiatrist as quickly as possible, but not later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient must ~~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 19. 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 clinical experience 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 20. 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 a 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 with less than 3 years of clinical experience, 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 a 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 with less than 3 years of clinical experience, 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 a clinical psychologist with at least 3 years of clinical experience 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 21. 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 a 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 with less than 3 years of clinical experience, 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 22. 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:

(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 clinical experience, each of whom 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.

(a) ~~(b)~~ "Department" means the Department of Children and Families.

Section 23. 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 24. 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 25. 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 26. 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) All hospitals with an emergency department, including hospital-based off-campus emergency departments, submit to the agency for approval a plan for assisting patients to gain access to appropriate care settings when patients either present at the emergency department with nonemergent health care needs or indicate, when receiving triage or treatment at the hospital, that they lack regular access to primary care, in order to divert such patients 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 its 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 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 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 patient's 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 a Medicaid enrollee, the agency shall establish a process for the hospital to share updated contact information for the patient, if in the hospital's possession, with the patient's managed care plan.

Section 27. Present subsections (5) and (6) of section 408.051, Florida Statutes, are redesignated 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 admit, 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 28. Present subsection (8) of section 409.909, Florida Statutes, is redesignated as subsection (10), a new subsection (8) and subsection (9) are added to that section, and paragraph (a) of subsection (6) of that section is amended, 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; and

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) If a hospital or qualifying institution receives state funds, including, but not limited to, intergovernmental transfers, under any of the programs established under this chapter, that hospital or qualifying institution must annually report to the agency data on each resident position funded.

(a) Specific to funds allocated under this section, other than funds allocated pursuant to subsection (5), the data required to be reported under this subsection must include, but is not limited to, all of the following:

1. 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.

2. The year the position was created and the current program year of the resident who is filling the position.

3. Whether the position is currently filled and whether there has been any period of time when it was not filled.

4. The specialty or subspecialty for which the position is accredited and whether the position is a fellowship position.

5. 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.

(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 their designees, from medical schools in this 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 an annual report to the Governor, the President of the Senate,

and the Speaker of the House of Representatives which 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 29. 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 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. 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, general 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 the 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 quarterly reports to the agency 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.—Qualified facilities 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 this 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 participating qualified facility or in a federally

designated health professional shortage area upon completion of their 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) SUNSET.—This section is repealed on July 1, 2034.

Section 30. 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 which it deems pertinent to the analysis. The report must demonstrate trends using applicable historical data. The agency shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The agency may contract with a third-party vendor to produce the report required under this subparagraph.

Section 31. 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 32. 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) and (3).

Section 33. Present subsections (3) through (8) of section 458.311, Florida Statutes, are redesignated as subsections (4) through (9), respectively, a new subsection (3) is added to that section, and paragraph (f) of subsection (1) and present subsections (3) and (5) of that section are amended, 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 34. Section 458.3124, Florida Statutes, is repealed.

Section 35. 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 36. Subsections (1) and (4) of section 458.3145, Florida Statutes, 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 37. 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 38. 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 Match 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 39. 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 Residency Match 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 licensed 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 40. 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 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 41. 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 42. 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 43. 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 44. 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 45. 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 enrolled lab school 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 Florida school district seeking to replicate the lab school's programs and must annually, beginning December 1, 2025, report to the President of the Senate and the Speaker of the House of Representatives on the development of such programs and their results.

Section 46. Paragraph (b) of subsection (3) of section 1009.8962, Florida Statutes, is 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 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 a minimum of 10 testing participants.

Section 47. Paragraph (f) of subsection (3) of section 381.4018, Florida Statutes, is amended 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 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.

Section 48. 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

Medical Education Reimbursement and Loan Repayment Program as defined by s. 381.402 ~~s. 1009.65~~ or through a federal loan repayment program which requires state matching funds. The department may use funds appropriated for the 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 49. Subsection (1) of 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:

(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 (4) ~~(3)~~;

(b) Before ~~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, the term "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.

Section 50. 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 51. 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 52. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $50 million in recurring 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 53. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $13.2 million in recurring 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 54. 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 55. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $40 million 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 56. Effective July 1, 2024, for the 2024-2025 fiscal year, 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 required by s. 1002.32, Florida Statutes. Each state university shall receive $500,000 from this appropriation.

Section 57. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $5 million 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 58. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $29,428,000 in recurring funds from the General Revenue Fund and $40,572,000 in recurring funds from the Medical Care Trust Fund are appropriated in the Graduate Medical Education category to the Agency for Health Care Administration for the Slots for Doctors Program established in s. 409.909, Florida Statutes.

Section 59. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $42,040,000 in recurring funds from the Grants and Donations Trust Fund and $57,960,000 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 60. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $64,030,325 in recurring funds from the General Revenue Fund and $88,277,774 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 61. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $14,682,841 in recurring funds from the General Revenue Fund and $20,243,041 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 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 62. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of $82,301,239 in recurring funds from the General Revenue Fund and $113,467,645 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 $195,768,884 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 63. 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 64. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $10 million 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 65. 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 66. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of $2.4 million in recurring funds from the General Revenue Fund is appropriated to the Agency for Health Care Administration for the purpose of providing behavioral health family navigators in state-licensed specialty hospitals providing comprehensive acute care services to children pursuant to s. 395.002(28), Florida Statutes, to help facilitate early access to mental health treatment. Each licensed specialty hospital shall receive $600,000 from this appropriation.

Section 67. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $12,067,327 in recurring funds from the General Revenue Fund, $127,300 in recurring funds from the

Refugee Assistance Trust Fund, and $16,812,576 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 68. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $14,378,863 in recurring funds from the General Revenue Fund and $19,823,951 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 69. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of $9,532,569 in recurring funds from the General Revenue Fund and $13,142,429 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 70. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

The Florida Senate

APPEARANCE RECORD

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12/12/23
Meeting Date

Health Policy
Committee

7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name David Mica JR.

Phone 850-352-8200

Address 306 E College Ave
Street

Email DavidM@FHA.org

Tallahassee FL 32312
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Hospital Association

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

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

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S-001 (08/10/2021)

The Florida Senate

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12/12/2023
Meeting Date

Health Policy
Committee

7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name Sarah Katherine Massey

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Email smassey@flchamber.com

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

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

Florida Chamber of Commerce

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S-001 (08/10/2021)

The Florida Senate

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12/12/2024
Meeting Date

Senate Health Policy
Committee

SB 7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name Melanie Brown-Woofter

Phone 850-224-6048

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Street

Email melanie@floridabha.org

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Council for Behavioral Healthcare

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

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

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S-001 (08/10/2021)

The Florida Senate

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12/12/2023
Meeting Date

Health Policy
Committee

SB 7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name Zayne Smith

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Street

Email zsmith@aarp.org

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP Florida

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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12-12-23
Meeting Date

Senate Health Policy
Committee

SB 7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name ALAN ABRAMOWITZ

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Address 2898 Mahan Dr.
Street

Email CEO@Arcflorida.org

Tallahassee FL 32308
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: The Arc of Florida

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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Dec 12, 23
Meeting Date

Senate Health Policy
Committee

SPB 7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jonathan Chapman / FACHC

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Street

Email jchapman@fachc.org

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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12-12-23
Meeting Date

Health Policy
Committee

7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name Tyler Sunny

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Street

Email tsunny@floridaarf.org

Tallahassee FL 32312
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida ARF

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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12/12/23
Meeting Date

Health Policy
Committee

#7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name Violet Gonzalez Phone 305-495-2686

Address Street 9040 Sunset Drive Miami, Fl. 33173 Email vgonzalez@sunrisegroup.org

City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: and also employed by Sunrise Community

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

Bill #7016

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

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DIR. OF GOV. AFFAIRS

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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12-12-23
Meeting Date

7016
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

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City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.
CEO of ADE, INC.
#7016

☐ I am a registered lobbyist, representing:

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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12/12/2023
Meeting Date

Health Policy
Committee

SB 7016
Bill Number or Topic

Amendment Barcode (if applicable)

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St. Cloud, FL 34769
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

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S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SPB 7018
INTRODUCER:	Health Policy Committee
SUBJECT:	Health Care Innovation
DATE:	December 14, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown, et al.	Brown		**HP Submitted as Comm. Bill/Fav**

I. Summary:

SPB 7018 sets forth legislative intent related to health care innovation in this state and creates a framework to implement that intent. The intent is to harness the innovation and creativity of entrepreneurs and businesses, in collaboration with the state's health care system and stakeholders, to lead the discussion on innovations that will address challenges in the health care system and to transform the delivery and strengthen the quality of health care in Florida.

The bill creates the Health Care Innovation Council, a 15-member council within the Department of Health (DOH) to facilitate public meetings across the state to lead discussions with innovators, developers, and implementers of technologies, workforce pathways, service delivery models, or other solutions. Based on the public input and information gathered at public meetings, the bill requires the council to create best practice recommendations and focus areas for the advancement of the delivery of health care in Florida, with an emphasis on:

- Increasing efficiency in the delivery of health care;
- Reducing strain on the health care workforce;
- Increasing public access to health care;
- Improving patient outcomes;
- Reducing unnecessary emergency department visits; and
- Reducing costs for patients and the state without reducing the quality of patient care.

The bill creates a revolving loan program within the DOH to provide low-interest loans to applicants to implement one or more innovative technologies, workforce pathways, or service delivery models in order to:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or
- A combination thereof to improve the quality and delivery of health care in measureable and sustainable ways that will lower costs and allow that value to be passed onto health care consumer.

The council will review loan applications and submit to the DOH a prioritized list of proposals recommended for funding. Loan recipients enter into agreements with the DOH for loans of up to 10-year terms for up to 50 percent of the proposal costs, or up to 80 percent of the costs for an applicant that is located in a rural or medically underserved area and is either a rural hospital or a nonprofit entity that accepts Medicaid patients.

The bill requires both the council and the DOH to publicly report certain information related to the activities required under the bill and requires the Office of Economic and Demographic Research (EDR) and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to evaluate specified aspects of the revolving loan program every five years.

The bill makes the following appropriations:

- For State Fiscal Year 2023-2024, appropriates $250,000 in nonrecurring General Revenue funds for the DOH to support the council.
- For State Fiscal Year 2024-2025, appropriates $1 million in recurring General Revenue funds for the DOH to support the council.
- For State Fiscal Years 2024-2025 through 2034-2035:
  - Requires the Chief Financial Officer by August 1 each year to transfer $75 million from the General Revenue Fund to the Grants and Donations Trust Fund in the DOH.
  - Appropriates $75 million in nonrecurring funds from the Grants and Donations Trust Fund each year for the DOH to make loans under the revolving loan program. The DOH may use up to three percent of the funds for administration.

The bill takes effect upon becoming a law.

II. Present Situation:

Challenges of the Health Care System

There are numerous challenges facing the health care system in the United States, including provider shortages, lack of access for certain populations, affordability, and ongoing challenges with health care outcomes for certain populations. Compared with other wealthy nations, Americans have poorer health, lower life expectancy, and less access to health care.[1]

Health Care Professional Shortages

The United State. has a current health care professional shortage. The U. S. Department of Health and Human Services designates an area, population group, or facility as a Health Professional Shortage Area (HPSA) if it is experiencing a shortage of professionals.[2] The three types of HPSAs are:

[1] Centers for Disease Control and Prevention, *U.S. Health Disadvantage: Causes and Potential Solutions*, available at https://www.cdc.gov/policy/chep/health/index.html (last visited December 3, 2023).
[2] U.S. Department of Health and Human Services, Guidance Portal, *Health Professional Shortage Areas (HPSAs and Medically Underserved Populations (MUA/P) Shortage Designation Types* (Aug. 1, 2019), available at https://www.hhs.gov/guidance/document/hpsa-and-muap-shortage-designation-types (last visited December 4, 2023).

- Geographic HPSAs, which have a shortage of services for the entire population within an established geographic area;
- Populations HPSAs, which have a shortage of services for a particular population subset within an established geographic area, such as low income, migrant farmworker, or Medicaid eligible; and
- Facility HPSAs, which indicate shortages in facilities such as correctional facilities, state or county hospitals with a shortage of psychiatrists, and other public or non-private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers.

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.[3]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population.[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] By 2030, all baby-boomers will be over the age of 65, and by 2034, it is projected that the number of individuals over the age of 65 will surpass the number of children under the age of 18 for the first time in U.S. history.[6] 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 workers may experience an extreme amount of stress due to the demanding work conditions, including taxing work, exposure to infectious diseases, long hours, and challenging interactions with coworkers, patients, and their families.[7] Prior to the COVID-19 pandemic, the National Academy of Medicine found that burnout had reached a crisis level, with 35-45 percent of nurses and physicians and 45-60 percent of medical students and residents reporting symptoms of burnout.[8] During the pandemic, the high levels of stress and the increased demands

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[3] 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 December 4, 2023).
[4] The U.S. population is projected to increase from almost 336 million in 2023 to nearly 370 million in 2080, before decreasing to 366 million in 2100. *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 December 4, 2023).
[5] *Id*, at p. 33.
[6] J. Vespa, L. Medina, and D. Armstrong, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060* (Mar. 208, rev. Feb, 2020), available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited December 4, 2023).
[7] J. Nigam, et. al., *Vital Signs: Health Worker-Perceived Working Conditions and Symptoms of Poor Mental Health – Quality of Worklife Survey, United States, 2018-2022*, MORBIDITY AND MORTALITY WEEKLY REPORT (Oct. 24, 2023), available at https://www.cdc.gov/mmwr/volumes/72/wr/pdfs/mm7244e1-H.pdf (last visited December 4, 2023).
[8] Office of the Surgeon General, *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce* (2022),, available at https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf (last visited December 4, 2023). "Burnout" is an occupational syndrome characterized by a high degree of emotional exhaustion and depersonalization and a low sense of personal accomplishment at work.

for care led to record numbers of health care workers quitting or planning to quit.[9] In 2022, nearly one half of health care workers reported burnout.[10]

Florida is not immune to the national problem and is also experiencing a health care practitioner shortage. This is evidenced by the fact that as of September 30, 2023, 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.[11]

According to data from the DOH, by 2035, Florida will need 17,924 physicians, 50,700 registered nurses, and 4,000 licensed practical nurses to meet the demand in Florida.[12] In the next five years almost 10 percent of Florida physicians are planning to retire, and in nine counties, at least 25 percent of physicians are planning to retire.[13] Nurses make up the largest segment of Florida's health care workforce. Approximately 20 percent of the nursing workforce is over the age of 60 and may leave the workforce in the next five to ten years.[14]

Access to Health Care

Access to health care means the timely use of personal health services to achieve the best possible health outcomes.[15] There are several barriers that limit an individual's access to health care services. Some lack access because they reside in a medically underserved area or are members of a medically underserved population, which means that they lack access to primary health care services.[16] Florida has approximately 130 federally designated medically underserved areas or populations.[17]

Other factors that play a role in access to health care include health care affordability and the lack of health insurance coverage.[18] Studies show that having health insurance is associated with improved access to health services and better health monitoring. Additionally, nonfinancial

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[9] *Id.* at p. 14.
[10] *Supra*, note 7.
[11] 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 December 4, 2023). To generate the report, select "Designated HPSA Quarterly Summary."
[12] Presentation before the Florida Senate Committee on Health Policy by Emma Spencer, Department of Health, *Florida's Physician and Nursing Workforce* (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited December 4, 2023).
[13] *Id*. Those counties are Glades, Gulf, Hamilton, Madison, Union, Calhoun, Hendry, Levy, and Liberty.
[14] *Id*.
[15] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030, *Access to Health Services*, available at https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services (last visited December 4, 2023). (Hereinafter "Healthy People 2030").
[16] Health and Resources Services Administration, *What is Shortage Designation?*, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation (last visited December 4, 2023).
[17] *See*, Heath Resources and Services Administration, *MUA Find*, available at https://data.hrsa.gov/tools/shortage-area/mua-find (last visited December 4, 2023). To generate a list of medically underserved areas and populations, select Florida as the search criteria.
[18] Centers for Disease Control and Prevention, Division of Heart Disease and Stroke Prevention, *Health Care Access*, available at https://www.cdc.gov/dhdsp/health_equity/health-care-access.htm (last visited December 4, 2023).

barriers significantly impact a patient's ability to access care. Among the most prevalent nonfinancial barriers are the ability to get an appointment and inconvenient or unreliable transportation.[19]

Health Care Outcomes

Although the United States spends more on health care per capita than other wealthy nations, it has some of the worst health care outcomes, according to an issue brief published by The Commonwealth Fund. Compared to other wealthy nations, the U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates, according to the issue brief. [20]

Sixty percent of adults in the U.S. have a chronic health condition, and 40 percent have two or more.[21] A chronic condition is a physical or mental health condition that lasts more than one year and causes functional restrictions or requires ongoing monitoring or treatment.[22] Chronic health conditions are the leading drivers of the nation's $4.1 trillion in health care costs, accounting for nearly 75 percent of aggregate health spending.[23] More than two thirds of all deaths are caused by one or more of the five most prevalent chronic health conditions: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. Unfortunately, these outcomes are because of the nation's inability to effectively manage chronic conditions, which could be achieved by reducing unhealthy behaviors.[24]

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.[25] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019. The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births. 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,

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[19] Healthy People 2030, *supra*, note 156.
[20] M. Gunja, Evan Gumas, and R. Williams, The Commonwealth Fund, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Jan. 31, 2023), available at https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 (last visited December 4, 2023). Other wealthy nations included in the study are Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland, and the United Kingdom.
[21] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *About Chronic Diseases*, available at https://www.cdc.gov/chronicdisease/about/index.htm (last visited December 4, 2023).
[22] W. Raghupathi and V. Rahupathi, *An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health*, INTERNATIONAL JOURNAL ON ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH, 15(3):431 (Mar. 2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5876976/ (last visited December 4, 2023).
[23] *Id.*, and CDC, s*upra*, note 22.
[24] *Id.*
[25] U.S. Department 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 November 9, 2023).

respectively.[26] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[27]

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.[28] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida.

Infant mortality is the death of an infant before his or her first birthday. The leading causes of infant death are:

- Birth defects;
- Preterm birth and low birth weight;
- Sudden infant death syndrome;
- Injuries (i.e. suffocation); and
- Maternal pregnancy complications.[29]

The 2022 infant mortality rate in the U.S. is projected to be 5.6 deaths per 1,000 live births, which is three percent higher than the infant mortality rate in 2021 (5.44).[30] Except for the infants of Asian mothers, mortality rates have increased for all races: American Indian and Alaska native infants from 7.46 to 9.06; white infants from 4.36 to 4.52, black infants from 10.55 to 10.86, native Hawaiian and other Pacific Islander infants from 7.76 to 8.50, and Hispanic infants from 4.79 to 4.88 per 1,000 live births.[31] From 2021 to 2022, Florida's infant mortality rate increased from 5.90 to 5.98 per 1,000 live births. In 2020, the infant mortality rate was more than double the rate for white and Hispanic infants in Florida.[32]

Advancements in Health Care

In the last century, there have been tremendous advances in health care. From the development of vaccines to suppress the spread of diseases that were once considered debilitating or fatal,

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[26] 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 December 4, 2023).

[27] 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 4, 2023).

[28] Presentation before the Florida Senate Committee on Health Policy by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Secretary for Health, Department of Health, *Telehealth Minority Care Pilot Program* (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited December 4, 2023).

[29] Centers for Disease Control and Prevention, *Infant Mortality*, available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last visited December 4, 2023).

[30] D. Ely and K. Driscoll, Centers for Disease Control and Prevention, National Center for Health Statistics, *Infant Mortality in the United States: Provisional Data from the 2022 Period Linked Birth/Infant Death File*, Vital Statistics Rapid Release, Report No. 33 (Nov. 2023), available at https://www.cdc.gov/nchs/data/vsrr/vsrr033.pdf (last visited December 4, 2023).

[31] *Id.*

[32] Department of Health, *Infant Mortality in Florida*, available at https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/infant-mortality-FL-.pdf (last visited December 4, 2023).

such as polio,[33] to the first successful organ transplant in 1954, and the development of numerous technologies and medical devices that provide new options for care and treatment.[34] During the last century, there have been numerous clinical innovations, such as the development of medications to make once fatal diseases an almost curable disease, such as AIDS, and the use of genetics to allow for individualized cancer treatments.[35] Despite the many advances in health care technology, the health care delivery system has been slower to change.

Historically, health care primarily involved the prevention and treatment of disease and episodes of acute care; however, health care has evolved to be increasingly occupied with the management of chronic health conditions. Chronic illness is the leading cause of illness, disability, and death in the United States, and accounts for 78 percent of health care expenditures.[36]

Within recent years, and especially during the COVID-19 pandemic, there has been an increase in interest in alternative delivery systems. For example, prior to the pandemic, the use of telehealth was growing; however, during the pandemic, the use of the technology rose by more than 760 percent.[37] As a subset of telehealth, many health care practitioners also adopted the use of remote patient monitoring to manage acute and chronic conditions. Remote patient monitoring may be used to assess high blood pressure, diabetes, weight loss or gain, heart conditions, chronic obstructive pulmonary disease, sleep apnea, or asthma. Using remote patient monitoring may reduce hospitalizations, reduce the length of hospital stays, reduce emergency department visits, and provide better health outcomes, among other things.[38]

Another technological advance that has been widely adopted is the use of an electronic health record (EHR).[39] EHRs offer a number of benefits, such as automating certain tasks, reducing the incidence of medical errors, and making health information more readily available, which reduces duplication of tests, delays in treatment, and enables patients to make better informed decisions.[40]

In addition to advancements in health care technologies and delivery systems, there has also been an evolution in payment models. In recent years, there has been a move to value-based care

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[33] The vaccine for polio was developed in the early 1950s. *See* World Health Organization, *History of the Polio Vaccine*, available at https://www.who.int/news-room/spotlight/history-of-vaccination/history-of-polio-vaccination (last visited December 2, 2023).
[34] Institute of Medicine, *Evidence-Based Medicine and the Changing Nature of Healthcare: 2007 IOM Annual Meeting Summary*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK52825/ (last visited December 2, 2023).
[35] Gary Ahlquist, et. al, Strategy&, *The (R)evolution of Healthcare*, available at https://www.strategyand.pwc.com/gx/en/industries/health/the-revolution-of-healthcare.pdf (last visited December 2, 2023).
[36] Institute of Medicine, *supra*, note 37.
[37] Julia Shaver, M.D., *The State of Telehealth Before and After the COVID-19 Pandemic*, PRIMARY CARE 49(4): 517-530 (Dec. 2022), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/ (last visited December 2, 2023).
[38] Telehealth.HHS.gov, *Telehealth and Remote Patient Monitoring*, available at https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/telehealth-and-remote-patient-monitoring (last visited December 2, 2023).
[39] An electronic health record is a digital version of a patient's paper chart. *See* The Office of the National Coordinator for Health Information Technology, HealthIT.gov, *Frequently Asked Questions*, available at https://www.healthit.gov/faq/what-electronic-health-record-ehr (last visited December 3, 2023).
[40] Centers for Medicare and Medicaid Services, *Electronic Health Records*, available at https://www.cms.gov/priorities/key-initiatives/e-health/records (last visited December 3, 2023).

models. Under these models, providers, such as hospitals and physicians, are paid based on patient outcomes. Providers are rewarded for achievements such as helping the health of their patients to improve and reducing the effects of chronic illness.[41]

Health Care Innovation Initiatives

In recent years, both the state and federal governments have launched or funded programs to examine innovations in health care. Many of the programs were predicated on grants from the Center for Medicare and Medicaid Innovation (CMS Innovation Center).[42]

In 2010, Congress established the CMS Innovation Center to identify ways to improve health care quality and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[43] The CMS Innovation Center's demonstration projects and models measure the effect of potential program changes, while evaluation projects validate research and help to monitor the effectiveness of Medicare, Medicaid, and CHIP.[44]

The Office of Economic and Demographic Research

The Office of Economic and Demographic Research (EDR) is a research arm of the Legislature principally concerned with forecasting economic and social trends that affect policy making, revenues, and appropriations. EDR provides objective information to committee staffs and members of the Legislature in support of the policy making process. EDR publishes all of the official economic, demographic, revenue, and agency workload forecasts that are developed by Consensus Estimating Conferences and makes them available to the Legislature, state agencies, universities, research organizations, and the general public. EDR, through a contract with the University of Florida, arranges for annual estimates of population of each city and county in Florida, which provide the basis for revenue sharing programs.

The Office of Program Policy Analysis and Government Accountability

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

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[41] NEJM Catalyst, *What is Value-Based Healthcare?* (Jan. 1, 2017), available at https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558 (last visited December 3, 2023).
[42] For example, see the Delaware Center for Health Innovation, available at https://www.dehealthinnovation.org/; Rhode Island Health Care Innovation Initiative, available at https://eohhs.ri.gov/initiatives/healthcare-innovation; Oklahoma Center for Health Innovation and Effectiveness, available at https://oklahoma.gov/health/about-us/center-for-health-innovation-and-effectiveness.html (all sites last visited December 3, 2023).
[43] Centers for Medicare and Medicaid Services, *About the CMS Innovation Center*, available at https://www.cms.gov/priorities/innovation/About (last visited December 3, 2023).
[44] Centers for Medicare and Medicaid Services, *CMS Innovation Center Programs*, available at https://data.cms.gov/cms-innovation-center-programs (last visited December 3, 2023).

III. Effect of Proposed Changes:

This bill creates s. 381.4015, F.S.,[45] to set forth legislative intent related to health care innovation in this state and create a framework to implement such intent.

The intent is to harness the innovation and creativity of entrepreneurs and businesses, in collaboration with the state's health care system and stakeholders, to lead discussion on innovations that will address challenges in the health care system and transform the delivery and strengthen the quality of health care in Florida.

Health Care Innovation Council

The bill creates the Health Care Innovation Council, a 15-member council within the DOH. The Lieutenant Governor serves as the chair of the council and as an ex officio, nonvoting member. The Secretary of Health Care Administration, the Secretary of Children and Families, the director of the Agency for Persons with Disabilities, the State Surgeon General, and the Secretary of Elderly Affairs all serve as ex officio, nonvoting members. The chair of the Council of Florida Medical School Deans serves as a voting member.

The President of the Senate and the Speaker of the House of Representatives each make one appointment to the council. Legislative appointments must be a person from the health care sector who has senior level experience in reducing inefficiencies in health care delivery systems; from the private sector who has senior level experience in cybersecurity or software engineering in the health care sector; who has expertise in emerging technology that can be used in the delivery of health care; or who has experience in finance or investment or in management and operation of early stage companies.

The remainder of the council consists of the following appointments by the Governor:
- A licensed physician;
- An employee of a licensed hospital;
- A licensed nurse;
- A Florida resident to represent the interest of health care patients;
- An employee of a health insurer or health maintenance organization; and
- A representative of the long-term care facility industry.

Appointments must be made by July 1, 2024. Appointees serve two-year terms and may be reappointed for no more than four consecutive terms.[46] Vacancies are filled in the same manner as the appointment, and members whose terms are expired may continue to serve for up to six months until replaced or reappointed. Members serve without compensation but are entitled to per diem and travel expenses. A member may be removed for cause by the appointing entity. Members who are not already required to file a financial disclosure statement must file a disclosure of financial interests.

[45] The section expires on July 1, 2043.
[46] The bill provides that the legislative appointees, the physician, and the nurse all serve initial terms of three years in order to create staggered terms.

The bill requires the council to hold its first meeting by September 1, 2024. The council is required to meet at least quarterly at the call of the chair, and in order to provide an opportunity for the broadest public input, must hold a majority of its meetings during the year geographically dispersed across the state. Meetings are encouraged to provide opportunities for demonstrations or presentations of innovative solutions in person. The council is subject to the public records requirements under ch. 119, F.S., and the public meetings requirements of ch. 286, F.S.

A majority of the members represents a quorum, which is required for meetings and can be established by conducting the meeting using teleconference or other electronic means. An affirmative vote by a majority of members present at the meeting is necessary for any official action.

Council members may not vote or consider any matters which would directly benefit the member or which would benefit a relative or person or entity with which the member has a business relationship.[47]

State agencies and statutorily created state entities are required to assist and cooperate with the council as requested. The DOH is required to administratively support the council, including providing reasonable support staff and maintaining a website for the council.

Council Duties

The bill charges the council with several duties, including adoption of best practices and focus areas. The council is required to adopt a document that sets forth a mission statement, goals, and objectives for the council to function and meet the purposes of the law. This must be adopted by February 1, 2025, and updated as necessary.

The council must facilitate public meetings at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions. The work:

- Must cover concepts that address challenges to the health care system as they develop in real time and concepts that advance the delivery of health care in this state through technology and innovation.
- Must give consideration to how the concepts:
  - Increase efficiency in the health care system in this state;
  - Reduce strain on the state's health care workforce;
  - Improve patient outcomes;
  - Expand public access to health care services in this state; or
  - Reduce costs for patients and the state without reducing the quality of patient care.
- May consider broad community or statewide issues or needs to be addressed.
- May include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payers, patients, and the state.

[47] "Relative" is defined as a father, mother, son, daughter, husband, wife, brother, sister, grandparent, father-in-law, mother-in-law, son-in-law, or daughter-in-law. "Business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent company, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association.

- May include coordination with the Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other business incubators, development organizations, or institutions of higher education to include emerging and early stage concepts in the discussions.
- May bring information technology technical experts to lead discussions on recommended structures and integrations of information technology products, services, and solutions.

The bill requires the council to annually distinguish the most impactful concepts, projects, and initiatives. The recognition must be for those that the council finds to have a positive impact in Florida, have huge potential to scale that impact throughout this state through growth or replication, or are cutting-edge advancements, programs, or other innovations that have the capability to accelerate transformation of health care in Florida. The council may develop a logo for awardees to display.

The bill requires the council to use input received to develop and update best practice recommendations. The best practice recommendations must:

- Be made for health care service delivery models and focus on how to explore implementation of innovations and how to implement new technologies and strategies, at a minimum;
- Be distinguished by practice setting and with an emphasis on increasing efficiency in the delivery of health care, reducing strain on the health care workforce, increasing public access to health care, improving patient outcomes, reducing unnecessary emergency department visits, and reducing costs for patients and the state without reducing the quality of patient care; and
- Specifically for information technology, also recommend actions to guide the selection of technologies and innovations, which may include considerations for system-to-system integration, consistent user experiences for health care workers and patients, and patient education and practitioner training.
- Be updated as necessary.

The council must develop and update a list of focus areas for the advancement of the delivery of health care. The council can adopt broad or specific focus areas, and the bill sets forth topics that must be considered at a minimum, including:

- The health care workforce (such as approaches to cultivate interest in the workforce, efforts to improve the workforce, education pathways, and use of technology to reduce workforce burdens).
- The provision of patient care in the most appropriate setting and reduction of unnecessary emergency department visits (such as use of advanced technologies to improve patient outcomes, use of early detection devices, at-home patient monitoring, advanced at-home care, and advanced adaptive equipment).
- The delivery of primary care through methods, practices, or procedures that increase efficiencies.
- The technical aspects of the provision of health care (such as interoperability of electronic health records systems and the protection of health care data and systems).

The council's duties also include identifying and recommending changes to law or administrative changes that are necessary to advance, transform, or innovate health care or to implement the

council's duties or recommendations. The DOH is required to incorporate council recommendations into its duties, including updating administrative rules or procedures, as appropriate.

The council must submit an annual report each December 1 on the council's activities, including:
- An update on the status of the delivery of health care in Florida;
- Information on implementation of best practices by Florida health care industry stakeholders; and
- Highlights of exploration, development, or implementation of innovative technologies, workforce pathways, service delivery models, or other solutions by Florida health care industry stakeholders.

Revolving Loan Program

The bill creates a revolving loan program within the DOH to provide funding for applicants seeking to implement innovative solutions. Certain entities licensed, registered, or certified by the Agency for Health Care Administration and educational or clinical training providers in partnership with one of the entities, may apply for a loan.[48]

The bill requires the DOH to establish eligibility criteria that:
- Incorporate recommendations of the council based on input received, focus areas developed, and best practices recommended.
- Determine which proposals are likely to provide the greatest return to the state, taking into consideration the degree to which the proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

The bill provides that an applicant that has a conflict of interest relationship with a council member may not receive a loan unless the council member recused herself or himself from consideration of the application. If a council member voted to recommend an application for funding with which the member has a conflict of interest, the applicant may not be awarded a loan. A council member may not receive a loan under the program.

The DOH is required under the bill to set application periods to apply for loans and may set up to four application periods in a fiscal year. The DOH must work with the council if application periods include separate priority for current focus areas adopted by the council. The availability of loans will be publicized to stakeholders, education or training providers, and others. The DOH will receive the applications and determine whether the applications are complete and whether the applicant has demonstrated ability to repay the loan. Within 30 days of the close of the application period, the DOH will forward the complete applications to the council.

The council must review submitted applications using the criteria and processes and format adopted by the DOH by rule. The bill requires priority for applicants that are located in a rural or

[48] Those entities licensed, registered, or certified pursuant to s. 408.802, except for subsections (1), (3), (13), (23), and (25) of that sections, are eligible to apply.

medically underserved area and are either rural hospitals or nonprofit entities that accept Medicaid patients. A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, service delivery models, or other solutions in order to:

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or
- A combination of the above, which will improve the quality and delivery of health care in measurable and sustainable ways and which will lower costs and allow savings to be passed on to health care consumers.

Approved lists of recommended applications for funding, arranged in order of priority and as required by the application period, are to be submitted by the council to the DOH. The DOH is directed under the bill to award the loans based on demonstrated need and availability of funds.

Loans may be made for up to 50 percent of the total projected implementation costs, or up to 80 percent of the total projected implementation costs for an applicant that is located in a rural or medically underserved area and is either a rural hospital or a nonprofit entity that accepts Medicaid patients. However, the DOH may not award more than 10 percent of the total allocated funds for the fiscal year to a single applicant. An applicant may only receive one loan per fiscal year, and if the applicant has an outstanding loan, it may apply for a new loan only if the outstanding loan is in good standing.

The loan term is up to 10 years and may have an interest rate of up to 1 percent. Loan recipients must enter into written agreements with the DOH to receive the loan. At a minimum, the agreement must specify:

- The total amount of the award.
- The performance conditions that must be met, based upon the submitted proposal and the defined category or focus area, as applicable.
- The information to be reported on actual implementation costs, including the share from non-state resources.
- The schedule for payment.
- The data and progress reporting requirements and schedule.[49]
- Any sanctions that would apply for failure to meet performance conditions.

Loan recipients can request the DOH to provide technical assistance, if needed.

The DOH is required to maintain the loan funds in a separate account in its Grants and Donations Trust Fund. All loan repayments of principal must be returned to the revolving loan fund and made available to make loans. Loans appropriated to the program are not subject to reversion.

The DOH is authorized to contract with a third-party administrator to administer the revolving loan program, including loan servicing, and manage the revolving loan fund. A contract for a

[49] The DOH is required to develop uniform data reporting requirements in order to evaluate the performance of the implemented proposals. The data collected must be shared with the council.

third-party administrator must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

Technical Assistance for Funding Opportunities

The DOH must identify and publish on its website a list of federal, state, and private sources of funding opportunities available to implement innovative technologies and service delivery models in health care. The information must include details and eligibility requirements for each opportunity. The DOH must provide technical assistance to apply for such funding upon request and is encouraged to foster working relationships that will allow the department to refer interested applicants to appropriate contacts for the funding opportunities.

Rulemaking

The bill authorizes the DOH to adopt rules for the revolving loan program, including establishing the loan application process, eligibility criteria, and application requirements. The bill specifies that conditions are deemed met in order for the DOH to adopt emergency rules to implement this bill. The emergency rules are effective for six months after adoption and may be renewed until permanent rules are adopted pursuant to ch. 120, F.S.

Reporting

The bill requires the DOH to publish information on its website related to loan recipients, including the written agreements, the performance conditions and status, and the total amount of funds disbursed to date. Information related to a loan must be updated annually on the award date of the loan.

Each September 1, beginning in 2025, the DOH must post on its website a report on health care innovation which includes all of the following information:

- A summary of the adoption and implementation of recommendations of the council during the previous fiscal year.
- An evaluation of actions and related activities to meet the purposes set forth in the bill.
- Consolidated data based upon the uniform data reporting by funding recipients and an evaluation of how the provision of the loans has met the purposes set forth in the bill.
- The number of applications for loans, the types of proposals received, and an analysis on the relationship between the proposals and the purposes of the bill.
- The amount of funds allocated and awarded for each loan application period, as well as any funds not awarded in that period.
- The amount of funds paid out during the fiscal year and any funds repaid or unused.
- The number of persons assisted and outcomes of any technical assistance requested for loans and any federal, state, or private funding opportunities.

Evaluation

The bill directs EDR and OPPAGA to each evaluate specified aspects of the revolving loan program every five years, as follows.

The first report by EDR is due October 1, 2029, and must be a comprehensive financial and economic evaluation of the innovative solutions undertaken by the revolving loan program. The evaluation must include, but is not limited to, separate calculations of the state's return and the economic value to residents of this state and the identification of any cost savings to patients or the state and the impact on the state's health care workforce.

The first report by OPPAGA is due October 1, 2030, and must be an evaluation of the administration and efficiency of the revolving loan program. The evaluation must include, but is not limited to, the degree to which the collective proposals increased efficiency in the health care system in this state, improved patient outcomes, increased public access to health care, and achieved the cost savings identified in the EDR evaluation without reducing the quality of patient care.

Each report must include recommendations for consideration by the Legislature.

EDR and OPPAGA must be given access to all data necessary to complete their evaluations, including any confidential data. The offices may collaborate on data collection and analysis. The reports must be sent to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Appropriations

The bill makes the following appropriations:

- For State Fiscal Year 2023-2024, appropriates $250,000 in nonrecurring General Revenue funds for the DOH to support the council.
- For State Fiscal Year 2024-2025, appropriates $1 million in recurring General Revenue funds for the DOH to support the council.
- For State Fiscal Years 2024-2025 through 2034-2035:
  - Requires the Chief Financial Officer by August 1 each year to transfer $75 million from the General Revenue Fund to the Grants and Donations Trust Fund in the DOH.
  - Appropriates $75 million in nonrecurring funds from the Grants and Donations Trust Fund each year for the DOH to make loans under the revolving loan program. The DOH may use up to three percent of the funds for administration, including hiring a third-party administrator.

Effective Date

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Eligible applicants will be able to apply to receive a loan to implement innovative solutions, which will improve the quality and delivery of health care in Florida, improve the work environment for the state's health care workforce, lead to lower costs, and allow savings to be passed on to health care consumers.

C. Government Sector Impact:

The DOH will incur costs to administratively support the council, including travel and per diem expenses of members and website hosting, and to implement and administer the revolving loan program. The bill appropriates $250,000 nonrecurring in State Fiscal Year 2023-2024 and $1 million recurring beginning in State Fiscal Year 2024-2025 from the General Revenue Fund to the DOH to administratively support the council.

The bill requires the Chief Financial Officer to annually transfer, beginning in the 2024-2025 state fiscal year through the 2033-2034 state fiscal year, $75 million from the General Revenue Fund to the Grants and Donations Trust Fund of the DOH. The DOH is appropriated budget authority beginning in State Fiscal Year 2024-2025 through State Fiscal Year 2033-2034 to use the transferred funds for the revolving loan program. The DOH is authorized to use up to three percent of the appropriated funds to administer the program, including contracting with a third-party administrator to implement the revolving loan program. Because it is a revolving loan program, the DOH only needs budget authority for new appropriations, while the revolving aspect of the loan program will allow the DOH, or third-party administrator, to make loans from repayments for the life of the program.

OPPAGA will incur costs in 2030 and EDR will incur costs in 2029, and every five years thereafter, respectively, to conduct their evaluations of the program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 381.4015 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

399480

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
12/12/2023	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment

Delete lines 111 - 138
and insert:
b. A physician licensed under chapter 458 or chapter 459, appointed by the Governor.
c. A nurse licensed under chapter 465, appointed by the Governor.
d. An employee of a hospital licensed under chapter 395 who has executive-level experience, appointed by the Governor.

399480

e. A representative of the long-term care facility industry, appointed by the Governor.

f. An employee of a health insurer or health maintenance organization who has executive-level experience, appointed by the Governor.

g. A resident of this state who can represent the interest of health care patients in this state, appointed by the Governor.

3. The chair of the Council of Florida Medical School Deans shall serve as a voting member of the council.

4. The council shall be composed of the following ex officio, nonvoting members:

a. The State Surgeon General.

b. The Secretary of Health Care Administration.

c. The Secretary of Children and Families.

d. The director of the Agency for Persons with Disabilities.

e. The Secretary of Elderly Affairs.

5. Except for ex officio members, the term of all appointees shall be for 2 years unless otherwise specified. However, to achieve staggered terms, the appointees in sub-subparagraphs 2.a.-c. shall serve initial terms of 3 years. The

653458

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
12/12/2023	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Substitute for Amendment (399480)

Delete lines 111 - 138
and insert:
b. A physician licensed under chapter 458 or chapter 459, appointed by the Governor.
c. A nurse licensed under chapter 464, appointed by the Governor.
d. An employee of a hospital licensed under chapter 395 who has executive-level experience, appointed by the Governor.


653458

e. A representative of the long-term care facility industry, appointed by the Governor.

f. An employee of a health insurer or health maintenance organization who has executive-level experience, appointed by the Governor.

g. A resident of this state who can represent the interest of health care patients in this state, appointed by the Governor.

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d. The director of the Agency for Persons with Disabilities.

e. The Secretary of Elderly Affairs.

5. Except for ex officio members, the term of all appointees shall be for 2 years unless otherwise specified. However, to achieve staggered terms, the appointees in sub-subparagraphs 2.a.-c. shall serve initial terms of 3 years. The

807142

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
12/12/2023	.	
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The Committee on Health Policy (Harrell) recommended the following:

Senate Amendment

Delete lines 559 - 569
and insert:
a comprehensive financial and economic evaluation of the innovative solutions undertaken by the revolving loan program administered under this section. The evaluation must include, but need not be limited to, separate calculations of the state's return and the economic value to residents of this state, as well as the identification of any cost savings to patients or

807142

the state and the impact on the state's health care workforce.

(b) Beginning October 1, 2030, and every 5 years thereafter, the Office of Program Policy Analysis and Government Accountability (OPPAGA) shall develop and present to the Governor, the President of the Senate, and the Speaker of the House of Representatives an evaluation of the administration and efficiency of the revolving loan program administered under this section. The evaluation must include, but need not be limited to, the degree to which the collective proposals increased efficiency in the health care system in this state, improved patient outcomes, increased public access to health care, and achieved the cost savings identified in paragraph (a) without reducing the quality of patient care.

(c) Both the EDR and OPPAGA shall

FOR CONSIDERATION By the Committee on Health Policy

588-01751A-24 20247018pb

A bill to be entitled

An act relating to health care innovation; creating s. 381.4015, F.S.; defining terms; providing legislative intent; creating the Health Care Innovation Council within the Department of Health for a specified purpose; providing for membership, meetings, and conflicts of interest of the council; specifying conflicts of interest with respect to the revolving loan program established under the act; defining the terms "business relationship" and "relative"; specifying duties of the council; requiring the council, by a specified date, to adopt, and update as necessary, a certain document; requiring the council to submit annual reports to the Governor and the Legislature; requiring state agencies and statutorily created state entities to assist and cooperate with the council as requested; requiring the department to provide administrative support to the council; requiring the department to maintain a link to specified information on the homepage of its website; requiring the department to publish specified information on its website; requiring the department to provide technical assistance to certain applicants upon request; requiring the department to administer a revolving loan program for applicants seeking to implement certain health care innovations in this state; providing for administration of the program; requiring the department to adopt certain rules; specifying eligibility and application requirements;

588-01751A-24 20247018pb

specifying terms, authorized uses, and repayment options for loans; requiring the department to create and maintain a separate account in the Grants and Donations Trust Fund within the department to fund the revolving loan program; providing that funds for the program are not subject to reversion; authorizing the department to contract with a third party to administer the program, including loan servicing, and manage the revolving loan fund; specifying requirements for the contract; requiring the department to publish and update specified information and reports on its website annually; requiring the Office of Economic and Demographic Research and the Office of Program Policy Analysis and Government Accountability to each develop and present an evaluation of the program to the Governor and the Legislature every 5 years, beginning on specified dates; specifying requirements for the evaluations; requiring that the offices be given access to all data necessary to complete the evaluation, including confidential data; authorizing the offices to collaborate on data collection and analysis; requiring the department to adopt rules; providing for future expiration; authorizing the department to adopt emergency rules to implement the act; providing appropriations; providing an effective date.

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

Section 1. Section 381.4015, Florida Statutes, is created to read:

381.4015 Florida health care innovation.—

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

(a) "Council" means the Health Care Innovation Council.

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

(c) "Health care provider" means any person or entity licensed, certified, registered, or otherwise authorized by law to provide health care services in this state.

(2) LEGISLATIVE INTENT.—The Legislature intends to harness the innovation and creativity of entrepreneurs and businesses, together with the state's health care system and stakeholders, to lead the discussion and highlight advances and innovations that will address challenges in the health care system as they develop in real time and transform the delivery and strengthen the quality of health care in Florida. Innovative technologies, workforce pathways, service delivery models, or other solutions that improve the quality of care in measurable and sustainable ways, that can be replicated, and that will lower costs and allow that value to be passed on to health care consumers shall be highlighted for adoption across all neighborhoods and communities in this state.

(3) HEALTH CARE INNOVATION COUNCIL.—The Health Care Innovation Council, a council as defined in s. 20.03, is created within the department to tap into the best knowledge and experience available by regularly bringing together subject matter experts in a public forum to explore and discuss innovations in technology, workforce, and service delivery models that can be exhibited as best practices, implemented, or

scaled in order to improve the quality and delivery of health care in this state in measurable, sustainable, and reproducible ways.

(a) *Membership.*—

1. The Lieutenant Governor shall serve as an ex officio, nonvoting member and shall act as the council chair.

2. The council shall be composed of the following voting members, to be appointed by July 1, 2024:

a. One member appointed by the President of the Senate and one member appointed by the Speaker of the House of Representatives. The appointing officers shall make appointments prioritizing members who have the following experience:

(I) A representative of the health care sector who has senior level experience in reducing inefficiencies in health care delivery systems;

(II) A representative of the private sector who has senior level experience in cybersecurity or software engineering in the health care sector;

(III) A representative who has expertise in emerging technology that can be used in the delivery of health care; or

(IV) A representative who has experience in finance or investment or in management and operation of early stage companies.

b. The chair of the Council of Florida Medical School Deans.

c. A physician licensed under chapter 458 or chapter 459, appointed by the Governor.

d. A nurse licensed under chapter 465, appointed by the Governor.

e. An employee of a hospital licensed under chapter 395 who has executive-level experience, appointed by the Governor.

f. A representative of the long-term care facility industry, appointed by the Governor.

g. An employee of a health insurer or health maintenance organization who has executive-level experience, appointed by the Governor.

h. A resident of this state who can represent the interest of health care patients in this state, appointed by the Governor.

3. The council shall be composed of the following ex officio, nonvoting members:

a. The State Surgeon General.

b. The Secretary of Health Care Administration.

c. The Secretary of Children and Families.

d. The director of the Agency for Persons with Disabilities.

e. The Secretary of Elderly Affairs.

4. Except for ex officio members, the term of all appointees shall be for 2 years unless otherwise specified. However, to achieve staggered terms, the appointees in sub-subparagraphs 2.a.-d. shall serve initial terms of 3 years. The appointees may be reappointed for no more than four consecutive terms.

5. Any vacancy occurring on the council must be filled in the same manner as the original appointment. Any member who is appointed to fill a vacancy occurring because of death, resignation, or ineligibility for membership shall serve only for the unexpired term of the member's predecessor.

6. Members whose terms have expired may continue to serve until replaced or reappointed. However, members whose terms have expired may not serve longer than 6 months after the expiration of their terms.

7. Members shall serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

8. Members may be removed for cause by the appointing entity.

9. Each member of the council who is not otherwise required to file a financial disclosure statement pursuant to s. 8, Art. II of the State Constitution or s. 112.3144 must file a disclosure of financial interests pursuant to s. 112.3145.

(b) *Meetings.*—The council shall convene its first organizational meeting by September 1, 2024. Thereafter, the council shall meet as necessary, but at least quarterly, at the call of the chair. In order to provide an opportunity for the broadest public input, the chair shall ensure that a majority of the meetings held in a year are geographically dispersed within this state. As feasible, meetings are encouraged to provide an opportunity for presentation or demonstration of innovative solutions in person. A majority of the members of the council constitutes a quorum, and a meeting may not be held with less than a quorum present. In order to establish a quorum, the council may conduct its meetings through teleconference or other electronic means. The affirmative vote of a majority of the members of the council present is necessary for any official action by the council.

(c) *Conflicts of interest.*—

1. A council member may not vote on any matter that would provide:

a. Direct financial benefit to the member;

b. Financial benefit to a relative of the member, including an entity of which a relative is an officer, partner, director, or proprietor or in which the relative has a material interest; or

c. Financial benefit to a person or entity with whom the member has a business relationship.

2. With respect to the revolving loan program established in subsection (7):

a. Council members may not receive loans under the program; and

b. A person or entity that has a conflict-of-interest relationship with a council member as described in sub-subparagraph 1.b. or sub-subparagraph 1.c. may not receive a loan under the program unless that council member recused himself or herself from consideration of the person's or entity's application.

3. For purposes of this paragraph, the term:

a. "Business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent company, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association.

b. "Relative" means a father, mother, son, daughter, husband, wife, brother, sister, grandparent, father-in-law, mother-in-law, son-in-law, or daughter-in-law of a person.

(d) *Public meetings and records.*—The council and any

subcommittees it forms are subject to the provisions of chapter 119 relating to public records and the provisions of chapter 286 relating to public meetings.

(4) HEALTH CARE INNOVATION COUNCIL DUTIES.—In order to facilitate and implement this section, the council shall:

(a) By February 1, 2025, adopt and update as necessary a document that sets forth and describes a mission statement, goals, and objectives for the council to function and meet the purposes of this section.

(b) Facilitate public meetings across this state at which innovators, developers, and implementers of technologies, workforce pathways, service delivery models, and other solutions may present information and lead discussions on concepts that address challenges to the health care system as they develop in real time and advance the delivery of health care in this state through technology and innovation.

1. Consideration must be given to how such concepts increase efficiency in the health care system in this state, reduce strain on the state's health care workforce, improve patient outcomes, expand public access to health care services in this state, or reduce costs for patients and the state without reducing the quality of patient care.

2. Exploration and discussion of concepts may include how concepts can be supported, cross-functional, or scaled to meet the needs of health care consumers, including employers, payors, patients, and the state.

3. The council may coordinate with the Small Business Development Center Network, the Florida Opportunity Fund, the Institute for Commercialization of Florida Technology, and other

business incubators, development organizations, or institutions of higher education to include emerging and early stage innovators, developers, and implementers of technology, models, or solutions in health care in the exploration and discussion of concepts and breakthrough innovations.

4. To support adoption and implementation of innovations and advancements, specific meetings may be held which bring together technical experts, such as those in system integration, cloud computing, artificial intelligence, and cybersecurity, to lead discussions on recommended structures and integrations of information technology products and services and propose solutions that can make adoption and implementation efficient, effective, and economical.

5. The council may also highlight broad community or statewide issues or needs of providers and users of health care delivery and may facilitate public forums in order to explore and discuss the range of effective, efficient, and economical technology and innovative solutions that can be implemented.

(c) Annually distinguish the most impactful concepts by recognizing the innovators, developers, and implementers whose work is helping Floridians to live brighter and healthier lives. In seeking out projects, initiatives, and concepts that are having a positive impact in Florida, have huge potential to scale that impact throughout this state through growth or replication, or are cutting-edge advancements, programs, or other innovations that have the capability to accelerate transformation of health care in this state, the council may issue awards to recognize these strategic and innovative thinkers who are helping Floridians live brighter and healthier

lives. The council may develop a logo for the award for use by awardees to advertise their achievements and recognition.

(d) Consult with and solicit input from health care experts, health care providers, and technology and manufacturing experts in the health care or related fields, users of such innovations or systems, and the public to develop and update:

1. Best practice recommendations that will lead to the continuous modernization of the health care system in this state and make the Florida system a nationwide leader in innovation, technology, and service. At a minimum, recommendations must be made for how to explore implementation of innovations, how to implement new technologies and strategies, and health care service delivery models. As applicable, best practices must be distinguished by practice setting and with an emphasis on increasing efficiency in the delivery of health care, reducing strain on the health care workforce, increasing public access to health care, improving patient outcomes, reducing unnecessary emergency room visits, and reducing costs for patients and the state without reducing the quality of patient care. Specifically for information technology, best practices must also recommend actions to guide the selection of technologies and innovations, which may include, but need not be limited to, considerations for system-to-system integration, consistent user experiences for health care workers and patients, and patient education and practitioner training.

2. A list of focus areas in which to advance the delivery of health care in this state through innovative technologies, workforce pathways, or service delivery models. The focus areas may be broad or specific, but must, at a minimum, consider all

of the following topics:

a. The health care workforce. This topic includes, but is not limited to, all of the following:

(I) Approaches to cultivate interest and growth in the workforce, including concepts resulting in increases in the number of providers.

(II) Efforts to improve the use of the workforce, whether through techniques, training, or devices to increase effectiveness or efficiency.

(III) Educational pathways that connect students with employers or result in attainment of cost-efficient and timely degrees or credentials.

(IV) Use of technology to reduce the burden on the workforce during decisionmaking processes such as triage, but which leaves all final decisions to the health care practitioner.

b. The provision of patient care in the most appropriate setting and reduction of unnecessary emergency room visits. These topics include, but are not limited to, all of the following:

(I) Use of advanced technologies to improve patient outcomes, provide patient care, or improve patient quality of life.

(II) The use of early detection devices, including remote communications devices and diagnostic tools engineered for early detection and patient engagement.

(III) At-home patient monitoring devices and measures.

(IV) Advanced at-home health care.

(V) Advanced adaptive equipment.

c. The delivery of primary care through methods, practices, or procedures that increase efficiencies.

d. The technical aspects of the provision of health care. These aspects include, but are not limited to, all of the following:

(I) Interoperability of electronic health records systems and the impact on patient care coordination and administrative costs for health care systems.

(II) Cybersecurity and the protection of health care data and systems.

(e) Identify and recommend any changes to Florida law or changes that can be implemented without legislative action which are necessary to:

1. Advance, transform, or innovate in the delivery and strengthen the quality of health care in Florida, including removal or update of any regulatory barriers or governmental inefficiencies.

2. Implement the council's duties or recommendations.

(f) Recommend criteria for awarding loans as provided in subsection (7) to the department and review loan applications.

(g) Annually submit by December 1 a report of council activities and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives. At a minimum, the report must include an update on the status of the delivery of health care in this state; information on implementation of best practices by health care industry stakeholders in this state; and highlights of exploration, development, or implementation of innovative technologies, workforce pathways, service delivery models, or other solutions

by health care industry stakeholders in this state.

(5) AGENCY COOPERATION.—All state agencies and statutorily created state entities shall assist and cooperate with the council as requested.

(6) DEPARTMENT DUTIES.—The department shall, at a minimum, do all of the following to facilitate implementation of this section:

(a) Provide reasonable and necessary support staff and materials to assist the council in the performance of its duties.

(b) Maintain on the homepage of the department a link to a website dedicated to the council on which the department shall post information related to the council, including the outcomes of the duties of the council and annual reports as described in subsection (4).

(c) Identify and publish on its website a list of any sources of federal, state, or private funding available for implementation of innovative technologies and service delivery models in health care, including the details and eligibility requirements for each funding opportunity. Upon request, the department shall provide technical assistance to any person wanting to apply for such funding. If the entity with oversight of the funding opportunity provides technical assistance, the department may foster working relationships that allow the department to refer the person seeking funding to the appropriate contact for such assistance.

(d) Incorporate recommendations of the council into the department's duties or as part of the administration of this section, or update administrative rules or procedures as

appropriate based upon council recommendations.

(7) REVOLVING LOAN PROGRAM.—The department shall administer a revolving loan program for applicants seeking to implement innovative solutions in this state.

(a) *Administration.*—The council may make recommendations to the department for the administration of the loans. The department shall adopt rules:

1. Establishing an application process to submit and review funding proposals for loans. Such rules must also include the process for the council to review applications to ensure compliance with applicable laws, including those related to discrimination and conflicts of interest. If a council member participated in the vote of the council recommending an award for a proposal with which the council member has a conflict of interest, the division may not award the loan to that entity.

2. Establishing eligibility criteria to be applied by the council in recommending applications for the award of loans which:

a. Incorporate the recommendations of the council. The council shall recommend to the department criteria based upon input received and the focus areas developed. The council may recommend updated criteria as necessary, based upon the most recent input, best practice recommendations, or focus areas list.

b. Determine which proposals are likely to provide the greatest return to the state if funded, taking into consideration, at a minimum, the degree to which the proposal would increase efficiency in the health care system in this state, reduce strain on the state's health care workforce,

improve patient outcomes, increase public access to health care in this state, or provide cost savings to patients or the state without reducing the quality of patient care.

3. It deems necessary to administer the program, including, but not limited to, rules for application requirements, the ability of the applicant to properly administer funds, the professional excellence of the applicant, the fiscal stability of the applicant, the state or regional impact of the proposal, matching requirements for the proposal, and other requirements to further the purposes of the program.

(b) *Eligibility.*—

1. The following entities may apply for a revolving loan:

a. Entities licensed, registered, or certified by the Agency for Health Care Administration as provided under s. 408.802, except for those specified in s. 408.802(1), (3), (13), (23), or (25).

b. An education or clinical training provider in partnership with an entity under sub-subparagraph a.

2.a. Council members may not receive loans under the program.

b. An entity that has a conflict-of-interest relationship with a council member as described in sub-subparagraph (3)(c)1.b. or sub-subparagraph (3)(c)1.c. may not receive a loan under the program unless that council member recused himself or herself from consideration of the entity's application.

3. Priority must be given to applicants located in a rural or medically underserved area as designated by the department which are:

a. Rural hospitals as defined in s. 395.602(2).

b. Nonprofit entities that accept Medicaid patients.

4. The department may award a loan for up to 50 percent of the total projected implementation costs, or up to 80 percent of total projected implementation costs for an applicant under subparagraph 3. The applicant must demonstrate the source of funding it will use to cover the remainder of the total projected implementation costs, which funding must be from nonstate sources.

(c) *Applications.*—

1. The department shall set application periods to apply for loans. The department may set multiple application periods in a fiscal year, with up to four periods per year. The department shall coordinate with the council when establishing application periods to establish separate priority, in addition to eligibility, within the loan applications for defined categories based on the current focus area list. The department shall publicize the availability of loans under the program to stakeholders, education or training providers, and others.

2. Upon receipt of an application, the department shall determine whether the application is complete and the applicant has demonstrated the ability to repay the loan. Within 30 days after the close of the application period, the department shall forward all completed applications to the council for consideration.

3. The council shall review applications for loans under the criteria and pursuant to the processes and format adopted by the department. The council shall submit to the department for approval lists of applicants that it recommends for funding, arranged in order of priority and as required for the

application period.

4. A loan applicant must demonstrate plans to use the funds to implement one or more innovative technologies, workforce pathways, service delivery models, or other solutions in order to fill a demonstrated need; obtain or upgrade necessary equipment, hardware, and materials; adopt new technologies or systems; or a combination thereof which will improve the quality and delivery of health care in measurable and sustainable ways and which will lower costs and allow savings to be passed on to health care consumers.

(d) *Awards.*—

1. The amount of each loan must be based upon demonstrated need and availability of funds. The department may not award more than 10 percent of the total allocated funds for the fiscal year to a single loan applicant.

2. The interest rate for each loan may not exceed 1 percent.

3. The term of each loan is up to 10 years.

4. In order to equitably distribute limited state funding, applicants may apply for and be awarded only one loan per fiscal year. If a loan recipient has one or more outstanding loans at any time, the recipient may apply for funding for a new loan if the current loans are in good standing.

(e) *Written agreement.*—

1. Each loan recipient must enter into a written agreement with the department to receive the loan. At a minimum, the agreement with the applicant must specify all of the following:

a. The total amount of the award.

b. The performance conditions that must be met, based upon

the submitted proposal and the defined category or focus area, as applicable.

c. The information to be reported on actual implementation costs, including the share from nonstate resources.

d. The schedule for payment.

e. The data and progress reporting requirements and schedule.

f. Any sanctions that would apply for failure to meet performance conditions.

2. The department shall develop uniform data reporting requirements for loan recipients to evaluate the performance of the implemented proposals. Such data must be shared with the council.

3. If requested, the department shall provide technical assistance to loan recipients under the program.

(f) *Loan repayment.*—Loans become due and payable in accordance with the terms of the written agreement. All repayments of principal received by the department in a fiscal year shall be returned to the revolving loan fund and made available for loans to other applicants.

(g) *Revolving loan fund.*—The department shall create and maintain a separate account in the Grants and Donations Trust Fund within the department as a fund for the program. All repayments of principal must be returned to the revolving loan fund and made available as provided in this section. Notwithstanding s. 216.301, funds appropriated for the revolving loan program are not subject to reversion. The department may contract with a third-party administrator to administer the program, including loan servicing, and manage the revolving loan

fund. A contract for a third-party administrator which includes management of the revolving loan fund must, at a minimum, require maintenance of the revolving loan fund to ensure that the program may operate in a revolving manner.

(8) REPORTING.—The department shall publish on its website information related to loan recipients, including the written agreements, performance conditions and their status, and the total amount of loan funds disbursed to date. The department shall update the information annually on the award date. The department shall, beginning on September 1, 2025, and annually thereafter, post on its website a report on this section for the previous fiscal year which must include all of the following information:

(a) A summary of the adoption and implementation of recommendations of the council during the previous fiscal year.

(b) An evaluation of actions and related activities to meet the purposes set forth in this section.

(c) Consolidated data based upon the uniform data reporting by funding recipients and an evaluation of how the provision of the loans has met the purposes set forth in this section.

(d) The number of applications for loans, the types of proposals received, and an analysis on the relationship between the proposals and the purposes of this section.

(e) The amount of funds allocated and awarded for each loan application period, as well as any funds not awarded in that period.

(f) The amount of funds paid out during the fiscal year and any funds repaid or unused.

(g) The number of persons assisted and outcomes of any

technical assistance requested for loans and any federal, state, or private funding opportunities.

(9) EVALUATION.—

(a) Beginning October 1, 2029, and every 5 years thereafter, the Office of Economic and Demographic Research (EDR) shall develop and present to the Governor, the President of the Senate, and the Speaker of the House of Representatives an evaluation of the activities and administration of the revolving loan program conducted under this section.

(b) Beginning October 1, 2030, and every 5 years thereafter, the Office of Program Policy Analysis and Government Accountability (OPPAGA) shall develop and present to the Governor, the President of the Senate, and the Speaker of the House of Representatives an evaluation of the activities and administration of the revolving loan program conducted under this section.

(c) Both the EDR and OPPAGA shall evaluate the program for its effectiveness and value to the taxpayers of this state and include recommendations for consideration by the Legislature. The EDR and OPPAGA must be given access to all data necessary to complete the evaluation, including any confidential data. The offices may collaborate on data collection and analysis.

(10) RULES.—The department shall adopt rules to implement this section.

(11) EXPIRATION.—This section expires July 1, 2043.

Section 2. The Department of Health shall, and all conditions are deemed met to, adopt emergency rules pursuant to s. 120.54(4), Florida Statutes, for the purpose of implementing s. 381.4015, Florida Statutes. Notwithstanding any other law,

emergency rules adopted pursuant to this section are effective for 6 months after adoption and may be renewed during the pendency of the procedure to adopt permanent rules addressing the subject of the emergency rules.

Section 3. (1) For the 2023-2024 fiscal year, the sum of $250,000 in nonrecurring funds from the General Revenue Fund is appropriated to the Department of Health to implement and administer the Health Care Innovation Council under s. 381.4015, Florida Statutes.

(2) For the 2024-2025 fiscal year, the recurring sum of $1 million is appropriated from the General Revenue Fund to the Department of Health to implement and administer the Health Care Innovation Council under s. 381.4015, Florida Statutes.

(3) By August 1 of each year, beginning in the 2024-2025 fiscal year through the 2033-2034 fiscal year, the Chief Financial Officer shall transfer $75 million in nonrecurring funds from the General Revenue Fund to the Grants and Donations Trust Fund within the Department of Health. Each year, beginning in the 2024-2025 fiscal year through the 2033-2034 fiscal year, the nonrecurring sum of $75 million is appropriated from the Grants and Donations Trust Fund to the Department of Health for the revolving loan fund created in s. 381.4015, Florida Statutes. The department may use up to 3 percent of the appropriated funds for administrative costs to implement the revolving loan program.

Section 4. This act shall take effect upon becoming a law.

The Florida Senate

APPEARANCE RECORD

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

12/12/23
Meeting Date

Health Policy
Committee

7018
Bill Number or Topic

Amendment Barcode (if applicable)

Name David Mica, Sr. Phone 352-222-8700

Address 306 E College Ave Email DavidM@FlHA.org
Street

Tallahassee FL 32312
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Hospital Association

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

12/12/2024
Meeting Date

Senate Health Policy
Committee

SB 7018
Bill Number or Topic

Amendment Barcode (if applicable)

Name Melanie Brown-Woofter

Phone 850-224-6048

Address 316 East Park Ave
Street

Email melanie@floridabha.org

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Council for Behavioral Healthcare

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

12-Dec-23
Meeting Date

Health Policy
Committee

SPB 7018
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jonathan Chapman / FACHC

Phone 850-755-3318

Address 2340 Hansen Lane
Street

Tallahassee FL 32301
City State Zip

Email jchapman@fachc.org

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

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

S-001 (08/10/2021)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Fiscal Policy
Governmental Oversight and Accountability
Health Policy
Judiciary

SELECT COMMITTEE:
Select Committee on Resiliency, *Chair*

JOINT COMMITTEE:
Joint Legislative Budget Commission

SENATOR BEN ALBRITTON
Majority Leader
27th District

December 12, 2023

Chair Burton,

I apologize for my absence due to a last minute issue that arose. Would you please excuse my absence from the Health Policy committee meeting on December 12th, 2023.

Apologies,

REPLY TO:
❒ 150 North Central Avenue, Bartow, Florida 33830 (863) 534-0073
❒ 410 Taylor Street, Suite 106, Punta Gorda, Florida 33950 (941) 575-5717
❒ 318 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5027

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Fiscal Policy
Governmental Oversight and Accountability
Health Policy
Judiciary

SELECT COMMITTEE:
Select Committee on Resiliency, *Chair*

JOINT COMMITTEE:
Joint Legislative Budget Commission

SENATOR BEN ALBRITTON
Majority Leader
27th District

December 12, 2023

Chair Burton,

In my absence during the Health Policy committee, I would like to be shown as voting in favor for SPB 7016 and SPB 7018.

Thank you,

REPLY TO:
❒ 150 North Central Avenue, Bartow, Florida 33830 (863) 534-0073
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KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 12/12/2023 4:03:31 PM
Ends: 12/12/2023 4:49:23 PM Length: 00:45:53

4:03:31 PM	Chair Burton calls meeting to order
4:03:44 PM	Sen. Albritton is excused from today's meeting
4:03:47 PM	Roll call and quorum verification
4:03:51 PM	Sen. Burton passes gavel to vice-chair Brodeur
4:04:24 PM	SPB 7016 by Chair Burton
4:04:49 PM	Chair Burton explains bill
4:08:31 PM	amendment 268962 by Sen. Harrell
4:09:48 PM	no questions, no public testimony, no debate on amendment
4:10:04 PM	amendment adopted
4:10:09 PM	amendment 233850 by Sen. Harrell
4:11:15 PM	no questions, testimony, or debate
4:11:28 PM	amendment adopted
4:11:32 PM	amendment 769026 by Sen. Harrell
4:12:14 PM	no questions, testimony
4:12:30 PM	Sen. Burton has a comment
4:12:40 PM	amendment adopted
4:12:48 PM	back on bill as amended - Sen. Davis recognized
4:13:46 PM	Sen. Burton responds
4:14:50 PM	Sen. Davis for additional questions
4:15:21 PM	Sen. Burton
4:16:15 PM	Sen. Davis
4:16:32 PM	Sen. Burton
4:17:02 PM	Sen. Book recognized
4:17:41 PM	Sen. Burton responds
4:17:48 PM	Sen. Book again
4:18:30 PM	Sen. Burton
4:18:51 PM	Sen. Book
4:18:56 PM	Sen. Burton
4:19:06 PM	Sen. Osgood for a question
4:19:45 PM	Sen. Burton
4:20:33 PM	Sen. Davis for a question
4:21:20 PM	Sen. Burton
4:22:32 PM	Sen. Davis for a follow-up
4:23:08 PM	Sen. Burton responds
4:23:53 PM	David Mica Jr. w/ the Fla. Hospital Assn. speaks for the bill
4:27:12 PM	Sarah Katherine Massey, w/ Fla. Chamber of Commerce, waives in support
4:27:19 PM	Melanie Brown Woofter, w/ Fla. Council for Behavioral Healthcare, waives in support
4:27:24 PM	Zayne Smith, w/ AARP Fla., waives in support
4:27:30 PM	Alan Abramowitz, w/ The Arc of Fla., waives in support
4:27:33 PM	Jonathan Chapman, w/ FACHC, waives in support
4:27:40 PM	Tyler Sununu, w/ Fla. ARF, waives in support
4:27:46 PM	Violet Gonzalez, Dir. of Gov't Affairs of Sunrise Community, waives in support
4:27:54 PM	Helena del Monte, CEO of ADE, Inc., waives in support
4:28:04 PM	Kevin Johnson, w/ Magnify of C. Fla., waives in support
4:28:23 PM	Sen. Harrell in debate
4:29:36 PM	Sen. Garcia recognized
4:30:27 PM	Vice Chair Brodeur makes a comment
4:31:47 PM	Sen. Burton closes on SPB 7016
4:34:09 PM	A motion by Sen. Burton to move SPB 7016 as a committee bill
4:34:29 PM	Roll call - SPB 7016 reported favorably
4:35:05 PM	Vice-chair Brodeur returns gavel to Chair Burton
4:35:18 PM	SPB 7018 by Sen. Harrell

4:35:31 PM Sen. Harrell explains bill
4:40:56 PM amendment 399480 has substitute amendment 653458 by Harrell
4:41:49 PM Sen. Harrell waives close - substitute amendment adopted
4:42:03 PM amendment 807142 by Sen. Harrell is explained
4:42:44 PM Sen. Harrell waives close on amendment - it's adopted
4:42:57 PM Back on bill as amended, Sen. Davis has a question
4:43:22 PM Sen. Harrell responds; Sen. Davis with a follow-up
4:44:24 PM Sen. Harrell responds
4:44:59 PM Sen. Davis
4:45:31 PM Sen. Harrell
4:46:55 PM David Mica, Jr, w/ Fla. Hosp. Assn., speaks in favor of bill as amended
4:47:35 PM Melanie Brown-Woofter waives in support
4:47:49 PM Jonathan Chapman waives in support
4:48:00 PM Sen. Harrell closes on bill
4:48:19 PM Sen. Harrell moves to submit as a committee bill - motion adopted
4:48:47 PM SPB 7018 roll call - reported favorably as a committee bill
4:49:07 PM Sen. Brodeur moves to adjourn