

Tab 1	SB 40 by Sharief ; Identical to H 00163 Medicaid Providers
Tab 2	SB 68 by Harrell ; Similar to H 00355 Health Care Patient Protection
Tab 3	SB 154 by Harrell ; Similar to H 00151 Mobile Opportunity by Interstate Licensure Endorsement Act
Tab 4	SB 254 by Harrell ; Compare to H 00121 Nursing Education Programs

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Harrell, Vice Chair

MEETING DATE: Tuesday, November 18, 2025

TIME: 10:00 a.m.—12:00 noon

PLACE: Pat Thomas Committee Room, 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	SB 40 Sharief (Identical H 163)	Medicaid Providers; Requiring the Agency for Health Care Administration to include specified requirements in its contracts with Medicaid managed care plans; defining the term “outside of regular business hours”, etc. HP 11/18/2025 AHS FP	
2	SB 68 Harrell (Similar H 355)	Health Care Patient Protection; Requiring hospitals with emergency departments to develop and implement policies and procedures and conduct training; authorizing a hospital with an emergency department to conduct the National Pediatric Readiness Project’s Open Assessment under certain circumstances; requiring the Agency for Health Care Administration to adopt certain rules for comprehensive emergency management plans, etc. HP 11/18/2025 AHS FP	
3	SB 154 Harrell (Similar H 151)	Mobile Opportunity by Interstate Licensure Endorsement Act; Revising the list of persons ineligible for a license by endorsement under the act, etc. HP 11/18/2025 AHS RC	

COMMITTEE MEETING EXPANDED AGENDA

Health Policy

Tuesday, November 18, 2025, 10:00 a.m.—12:00 noon

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	SB 254 Harrell (Compare H 121)	Nursing Education Programs; Requiring the Department of Health to issue temporary provisional licenses to graduate registered nurses and graduate licensed practical nurses; revising application requirements for nursing education program approval; requiring the Florida Center for Nursing to develop graduate nursing preceptorship standards by a specified date; authorizing agents or employees of the department to conduct onsite evaluations and inspections of approved and accredited nursing education programs, etc. HP 11/18/2025 AHS FP	
5	Review of Health Care Practitioner Interstate Licensure Compacts by the Office of Program Policy Analysis and Government Accountability (OPPAGA)		
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: SB 40

INTRODUCER: Senator Sharief

SUBJECT: Medicaid Providers

DATE: November 17, 2025

REVISED: _____

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

I. Summary:

SB 40 amends s. 409.967, F.S., to requires the Agency for Health Care Administration to establish specific standards to ensure Florida Medicaid enrollees have access to network providers during state holidays and outside regular business hours.

The bill is not anticipated to have fiscal impact on state expenditures or revenues.

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

II. Present Situation:

Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) is created under s. 20.42, F.S., to be the chief health policy and planning entity for the state, responsible for health facility licensure, inspection, and regulatory enforcement,¹ as well as the administration of Florida's Medicaid program.²

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.³ The federal Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services is responsible for administering the Medicaid

¹ Agency for Health Care Administration, *Health Quality Assurance*, available at <https://ahca.myflorida.com/health-quality-assurance> (last visited Nov. 14, 2025).

² Section 409.902, F.S.

³ Medicaid.gov, *Medicaid*, available at <https://www.medicaid.gov/medicaid> (last visited Nov. 14, 2025).

program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians and is financed through state and federal funds.⁴

Statewide Medicaid Managed Care

Approximately 72.7 percent of Florida Medicaid recipients⁵ receive services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.⁶ The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care Managed Care (LTCMC), and the Prepaid Dental Health program.⁷ Among these three components, Florida's SMMC program offers a health care package covering acute, preventive, behavioral health, prescribed drugs, long-term care, and dental services. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.

The AHCA awarded contracts to the current SMMC plans through a competitive procurement process called an Invitation to Negotiate (ITN). The AHCA awarded and executed new contracts for SMMC 3.0 in October 2024 and officially rolled out the new SMMC 3.0 program on February 1, 2025. The rate year for the SMMC contracts is October 1 through September 30 of the following calendar year.

Managed care plans providing MMA program services are required to cover acute, preventive, and other health care services, such as:

- Hospital services;
- Physician services;
- Pharmacy services;
- Behavioral health services;
- Transportation to medical services;
- Nursing facility services; and
- Other service benefits, including, but not limited to, medical equipment and supplies, therapies, and home health services.

The AHCA contracts with LTCMC plans in each region to provide long-term care services, including all home and community-based waiver services, through their provider networks. Currently, all the LTCMC plans contracted with the AHCA are also contracted to provide MMA services, streamlining care with a more comprehensive enrollment approach where a Medicaid recipient can enroll with one plan for all services.

The SMMC program includes the following regions:⁸

⁴ Section 20.42, F.S.

⁵ The other 27.3 percent of recipients receive Medicaid services through the fee-for-service (FFS) delivery model, where providers contract directly with the AHCA to render services, billing and receiving reimbursement directly from the AHCA.

⁶ Agency for Health Care Administration, *Florida Statewide Medicaid Enrollment Report As of September 30, 2025 (including Medikids Population)*, available at https://ahca.myflorida.com/content/download/27345/file/ENR_202509.xls (last visited Nov. 14, 2025).

⁷ Agency for Health Care Administration, *Statewide Medicaid Managed Care*, available at <https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care> (last visited Nov. 14, 2025).

⁸ Section 409.966(2), F.S.

- Region A, which consists of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties.
- Region B, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia counties.
- Region C, which consists of Pasco and Pinellas counties.
- Region D, which consists of Hardee, Highlands, Hillsborough, Manatee, and Polk counties.
- Region E, which consists of Brevard, Orange, Osceola, and Seminole counties.
- Region F, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota counties.
- Region G, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties.
- Region H, which consists of Broward County.
- Region I, which consists of Miami-Dade and Monroe counties.

Managed Care Plan Provider Networks

A provider network is a list of doctors, hospitals, and other health care providers that a managed care plan contracts with to provide medical care to its enrollees. These providers are commonly known as participating providers, and a provider that is not contracted with the plan is called a nonparticipating provider.⁹

SMMC Plan Accountability – Network Access and Adequacy

SMMC plans must adhere to all requirements as specified in their contracts with the AHCA, including requirements to enter into provider agreements with a sufficient number of providers to deliver all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided with reasonable promptness, including the utilization of nonparticipating providers.¹⁰ If the managed care plan declines to include individual or group providers in its provider network, the plan is required to give written notice to the affected provider(s) of the reason for its decision.^{11,12}

Prior to implementation of SMMC 3.0 on February 1, 2025, the AHCA indicated that the network sufficiency of each plan was assessed to ensure an adequate number of available providers exists within the plans' provider networks. Managed care plans are contractually required to develop a printed and online (electronic) provider network directory to assist enrollees in selecting from qualified providers. A plan must update its online provider database at least weekly and provide printed copies of provider directories to enrollees upon request, at no charge. A plan must have procedures to inform current enrollees and potential enrollees, upon request, of any changes to service delivery and/or provider network.

⁹ U.S. Department of Health & Human Services, Health Insurance Marketplace, *What You Should Know About Provider Networks*, available at <https://www.cms.gov/marketplace/outreach-and-education/what-you-should-know-provider-networks.pdf> (last visited Nov. 14, 2025).

¹⁰ 42 C.F.R. § 438.206(b)(4)

¹¹ 42 C.F.R. § 438.12(a)(1)

¹² Agency for Health Care Administration, *Senate Bill 40* (Sept. 25, 2025) (on file with Senate Committee on Health Policy).

On a regional basis, SMMC plans must notify the AHCA within seven business days of a decrease in the total number of primary care providers by more than five percent. Moreover, the plans are required to submit an Annual Network Development Plan¹³ that includes a description or explanation of the current status of their network for each service covered.¹⁴

Additionally, the plans are required to submit weekly Provider Network Verification (PNV) files,¹⁵ which include information on each plan's provider network. The AHCA monitors the PNV files to ensure contractually required provider network standards are being met. If a plan is not compliant with these standards, the AHCA has actions available through its contracts that can be applied, including liquidated damages.¹⁶ Managed care plans' online and printed provider directories are monitored monthly for accuracy and completeness. Furthermore, the AHCA monitors the networks to ensure that contractual provider-specific geographic access (time and distance) standards for enrollees in urban or rural counties are maintained.¹⁷

The required regional provider ratios and network adequacy standards, as well as the time and distance standards for covered services, providers, and facilities, are contained within the contracts between the AHCA and the Medicaid managed care plans.^{18,19,20}

After-hours Access

The current SMMC contracts, implemented in 2025, include negotiated performance standards for the availability of primary care providers for after-hours access. The AHCA negotiated that 40 percent of all plans' participating MMA primary care providers must offer after-hours appointments by the end of the 2025 contract year, covering the hours on Monday through Friday between 5:00 p.m. and 8:00 a.m. and all day Saturday and Sunday.²¹

By the end of the 2026 contract year, the negotiated performance standards require after-hours primary care provider availability from:

- At least 50 percent of a plan's participating MMA primary care providers in regions A, B, E, G, H, and I;
- At least 45 percent of a plan's participating MMA primary care providers in regions C and D; and

¹³ Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Attachment II – Core Contract Provisions* (Feb. 2025), Page 236 of 267, available at <https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf> (last visited Nov. 14, 2025).

¹⁴ *Supra* note 12.

¹⁵ *Supra* note 13, Page 234 of 267.

¹⁶ *Supra* note 13, Page 201 of 267.

¹⁷ *Supra* note 12.

¹⁸ Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-A – Managed Medical Assistance Program* (Feb. 2025), Pages 55-58, 60-61, available at <https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf> (last visited Nov. 14, 2025).

¹⁹ *Id.*, Pages 70-72.

²⁰ Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-B – Long-Term Care (LTC) Program* (Feb. 2025), Pages 32-34, available at <https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf> (last visited Nov. 14, 2025).

²¹ *Supra* note 12.

- At least 40 percent of a plan’s participating MMA primary care providers in Region F.²²

III. Effect of Proposed Changes:

Section 1 amends s. 409.967, F.S., to require the Agency for Health Care Administration to establish specific standards to ensure enrollees have access to network providers during state holidays and outside regular business hours. At least 50 percent of primary care providers participating in a Medicaid managed care plan provider network must offer appointment availability to Medicaid enrollees outside regular business hours.

The bill also defines the term “outside regular business hours” to mean Monday through Friday between 5:00 p.m. and 8:00 a.m. local time and all day Saturday and Sunday.

Section 2 provides that the bill takes effect July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under SB 40, Medicaid MMA plans contracted to cover regions C and D will be required to increase their percentage of participating primary care providers offering after-hours

²² *Id.*

access from 45 percent to 50 percent. Such plans covering Region F will be required to increase their percentage from 40 percent to 50 percent.

According to the AHCA, this could potentially result in plans negotiating higher provider rates to increase primary care provider participation in offering after-hours appointments or to expand the provider network to increase availability of after-hours appointments. However, the affected care plans all entered into agreements with the AHCA to increase participation of primary care providers offering after-hours appointments to 50 percent. Therefore, this potential rate difference has already been considered in managed care plan rate-setting.²³

C. Government Sector Impact:

For the reasons stated under “Private Sector Impact” (above), this bill is not anticipated to have fiscal impact on state expenditures or revenues.²⁴

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.967 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.

This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.

²³ *Id.*

²⁴ *Id.*

By Senator Sharief

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A bill to be entitled
An act relating to Medicaid providers; amending s.
409.967, F.S.; requiring the Agency for Health Care
Administration to include specified requirements in
its contracts with Medicaid managed care plans;
defining the term "outside of regular business hours";
providing an effective date.

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

Section 1. Paragraph (c) 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:

(c) Access.—

1. The agency shall establish specific standards for the
number, type, and regional distribution of providers in managed
care plan networks to ensure access to care for both adults and
children. Each plan must maintain a regionwide network of
providers in sufficient numbers to meet the access standards for
specific medical services for all recipients enrolled in the
plan. The exclusive use of mail-order pharmacies may not be
sufficient to meet network access standards. Consistent with the
standards established by the agency, provider networks may
include providers located outside the region.

2. The agency shall establish specific standards to ensure

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30 enrollees have access to network providers during state holidays
31 and outside of regular business hours. At least 50 percent of
32 primary care providers participating in a plan provider network
33 must offer appointment availability to Medicaid enrollees
34 outside of regular business hours. For the purposes of this
35 subparagraph, the term "outside of regular business hours" means
36 Monday through Friday between 5 p.m. and 8 a.m. local time and
37 all day Saturday and Sunday.

38 3. Each plan shall establish and maintain an accurate and
39 complete electronic database of contracted providers, including
40 information about licensure or registration, locations and hours
41 of operation, specialty credentials and other certifications,
42 specific performance indicators, and such other information as
43 the agency deems necessary. The database must be available
44 online to both the agency and the public and have the capability
45 to compare the availability of providers to network adequacy
46 standards and to accept and display feedback from each
47 provider's patients.

48 4. Each plan shall submit quarterly reports to the agency
49 identifying the number of enrollees assigned to each primary
50 care provider.

51 5. The agency shall conduct, or contract for, systematic
52 and continuous testing of the provider network databases
53 maintained by each plan to confirm accuracy, confirm that
54 behavioral health providers are accepting enrollees, and confirm
55 that enrollees have access to behavioral health services.

56 6.2- Each managed care plan shall ~~must~~ publish any
57 prescribed drug formulary or preferred drug list on the plan's
58 website in a manner that is accessible to and searchable by

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enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

~~7.3.~~ Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

~~8.4.~~ Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department is ~~shall be~~ the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and follow up ~~followup~~ on all medically necessary services

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88 recommended as a result of early and periodic screening,
89 diagnosis, and treatment.

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



The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 6, 2025

I respectfully request that **Senate Bill # 40**, relating to Medicaid Providers, be placed on the:

- ☐ committee agenda at your earliest possible convenience.
- ☒ next committee agenda.

A blue ink signature, appearing to read "B. Sharief", is written over a horizontal line.

Senator Barbara Sharief
Florida Senate, District 35

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 68

INTRODUCER: Senator Harrell

SUBJECT: Health Care Patient Protection

DATE: November 17, 2025 REVISED: _____

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

I. Summary:

SB 68 amends several sections of the Florida Statutes in order to require each hospital with an emergency department (ED) to develop and implement policies and procedures specific to the care of pediatric patients in its ED. The bill provides specific items that must be included in such policies and procedures as well as requiring training on the policies and procedures at least annually. Additionally, the bill requires each hospital's ED to designate a pediatric care coordinator and to conduct the National Pediatric Readiness Assessment (NPRA) on a timeframe established by the National Pediatric Readiness Project (NPRP).

The bill also requires the Agency for Health Care Administration (AHCA) to adopt rules to establish minimum standards for pediatric care in hospital EDs and to collect and publish each overall assessment score from the NPRA conducted by each hospital's ED.

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

II. Present Situation:

Hospital Licensure

In Florida, emergency departments (ED) are either located in a hospital or on separate premises of a licensed hospital. Any licensed hospital that has a dedicated ED may provide emergency services in a location separate from the hospital's main premises, known as a hospital-based off-campus emergency department.¹

Current law requires each hospital with an ED to screen, examine, and evaluate a patient who presents to the ED to determine if an emergency medical condition exists and, if it does, provide

¹ Section 395.002(13), F.S.

care, treatment, or surgery to relieve or eliminate the emergency medical condition.² Each hospital with an ED must provide emergency services and care³ 24 hours a day and must have at least one physician on-call and available within 30 minutes.⁴

Inventory of Hospital Emergency Services

Each hospital offering emergency services and care must report to the AHCA the services which are within the service capability of the hospital.⁵ The AHCA is required to maintain an inventory of hospitals with emergency services, including a list of the services within the service capability of the hospital, to assist emergency medical services providers and the general public in locating appropriate emergency medical care.⁶ If a hospital determines it is unable to provide a service on a 24-hour per day, 7-day per week, basis, either directly or indirectly through an arrangement with another hospital, the hospital must request a service exemption from the AHCA.⁷

Policies and Procedures

Each hospital offering emergency services and care is required to maintain written policies and procedures specifying the scope and conduct of their emergency services. The policies and procedures must be approved by the organized medical staff, reviewed at least annually, and must include:

- A process to designate a physician to serve as the director of the ED;
- A written description of the duties and responsibilities of all other health care personnel providing care within the ED;
- A planned formal training program on emergency access laws for all health care personnel working in the ED; and
- A control register to identify all persons seeking emergency care.⁸

Current law does not require EDs to have pediatric-specific policies and procedures.

Equipment and Supplies

Each hospital ED is required to provide diagnostic radiology services and clinical laboratory services and must ensure that an adequate supply of blood is available at all times. Hospitals EDs are also required to have certain equipment available for immediate use at all times, including:

- Oxygen and means of administration;

² Section 395.1041, F.S.

³ Section 395.002(9), F.S., “emergency services and care” means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

⁴ Fla. Admin. Code R. 59A-3.255(6)(e)(2014).

⁵ Section 395.1041(2), F.S.

⁶ Medical services listed in the inventory include: anesthesia; burn; cardiology; cardiovascular surgery; colon & rectal surgery; emergency medicine; endocrinology; gastroenterology; general surgery; gynecology; hematology; hyperbaric medicine; internal medicine; nephrology; neurology; neurosurgery; obstetrics; ophthalmology; oral/maxilla-facial surgery; orthopedics; otolaryngology; plastic surgery; podiatry; psychiatry; pulmonary medicine; radiology; thoracic surgery; urology; and vascular surgery.

⁷ Fla. Admin. Code R. 59A-3.255(4)(2014).

⁸ Fla. Admin. Code R. 59A-3.255(6)(e)(2014).

- Mechanical ventilatory assistance equipment, including airways, manual breathing bags, and ventilators;
- Cardiac defibrillators with synchronization capability;
- Respiratory and cardiac monitoring equipment;
- Thoracentises and closed thoracotomy sets;
- Tracheostomy or cricothyrotomy sets;
- Tourniquets;
- Vascular cutdown sets;
- Laryngoscopes and endotracheal tubes;
- Urinary catheters with closed volume urinary systems;
- Pleural and pericardial drainage sets;
- Minor surgical instruments;
- Splinting devices;
- Emergency obstetrical packs;
- Standard drugs as determined by the facility;
- Common poison antidotes;
- Syringes, needles, and surgical supplies;
- Parenteral fluids and infusion sets;
- Refrigerated storage for biologicals and other supplies; and
- Stable examination tables.⁹

Currently, there are no pediatric-specific equipment or supply standards for EDs.

Comprehensive Emergency Management Plans

All hospitals are required to develop and adopt a comprehensive emergency management plan for emergency care during an internal or external disaster or an emergency.¹⁰ Each hospital must review, update, and submit its plans annually to the respective county office of emergency management. A hospital's comprehensive emergency management plan must include the following:

- Provisions for the management of staff, including the distribution and assignment of responsibilities and functions;
- Education and training of personnel in carrying out their responsibilities in accordance with the adopted plan;
- Information about how the hospital plans to implement specific procedures outlined in the plan;
- Precautionary measures, including voluntary cessation of hospital admissions, to be taken in preparation and response to warnings of inclement weather, or other potential emergency conditions;
- Provisions for the management of patients, including the discharge of patients in the event of an evacuation order;
- Provisions for coordinating with other hospitals;

⁹ Fla. Admin. Code R. 59A-3.255(6)(g)(2014).

¹⁰ Section 395.1055(1)(c), F.S.

- Provisions for the individual identification of patients, including the transfer of patient records;
- Provisions to ensure that relocated patients arrive at designated hospitals;
- Provisions to ensure that medication needs will be reviewed and advance medication for relocated patients will be forwarded to the appropriate hospitals;
- Provisions for essential care and services for patients who may be relocated to the facility during a disaster or an emergency, including staffing, supplies, and identification of patients;
- Provisions for the management of supplies, communications, power, emergency equipment, and security;
- Provisions for coordination with designated agencies including the Red Cross and the county emergency management office; and
- Plans for the recovery phase of the operation.¹¹

Current law does not require hospitals to include any pediatric-specific provisions in their comprehensive emergency management plans.

Pediatric Care in Hospital Emergency Departments

Children represent approximately 25 percent of all ED visits in the U.S. each year.¹² According to a recent study conducted to evaluate the association between ED pediatric readiness and in-hospital mortality,¹³ pediatric patient deaths are 60 percent to 76 percent less likely to occur in an ED with high pediatric readiness. The study included 796,937 pediatric patient visits in 983 EDs over a six-year period (January 1, 2012, through December 31, 2017).

The study used the results of the 2013 National Pediatric Readiness Project Assessment to categorize each hospital ED in one of four levels of pediatric readiness (first quartile 0-58, second quartile 59-72, third quartile 73-87, and fourth quartile 88-100). Hospital EDs with an Assessment score of 88-100 were categorized as having high pediatric readiness. The study also concluded that if all 983 EDs had high pediatric readiness, an estimated 1,442 pediatric deaths may have been prevented.¹⁴

General hospital EDs (nonchildren's hospitals) primarily treat adults and may not be prepared to treat children because of low pediatric patient volume.¹⁵ More than 97 percent of EDs caring for children are general hospital EDs, accounting for 82 percent of pediatric ED visits. Most of these hospitals see less than 15 pediatric patients per day.¹⁶ Therefore, according to a joint policy

¹¹ Fla. Admin. Code R. 59A-3.078(2014).

¹² Remick KE, Hewes HA, Ely M, et al. National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic. *JAMA Netw Open*. 2023. available at [National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic | Pediatrics | JAMA Network Open | JAMA Network](#), (last visited Nov. 12, 2025).

¹³ Newgard CD, Lin A, Malveau S, et al. *Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care*. JAMA Network (January, 2023) available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800400> (last visited Nov. 12, 2025).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ The National Pediatric Readiness Project, Pediatric Readiness Saves Lives, available at https://media.emscenterimprovement.center/documents/EMS220628_ReadinessByTheNumbers_220830_ZekNYVF.pdf (last visited Nov. 12, 2025).

statement issued by the American Academy of pediatrics (AAP), the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA), “it is imperative that all hospital EDs have the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children.”¹⁷

The 2009 joint policy statement also included guidelines for care of children in the emergency department. In 2012, the Emergency Medical Services for Children (EMSC) Program, under the U.S. Department of Health and Human Services, used the guidelines to launch the National Pediatric Readiness Project, in partnership with the AAP, ACEP, and ENA.¹⁸

The National Pediatric Readiness Project

The National Pediatric Readiness Project (NPRP) is a quality improvement initiative offering state partnership grants to state governments and accredited schools of medicine to expand and improve emergency medical services for children in hospital EDs.¹⁹ The NPRP measures the performance of hospital EDs based on the following four metrics and includes program goals for each.²⁰

- Pediatric Readiness Recognition Programs – Program Goal: To increase the percent of hospitals with an ED recognized through a statewide, territorial, or regional standardized program that are able to stabilize and manage pediatric emergencies.
- Pediatric Emergency Care Coordinators – Program Goal: To increase the percent of hospitals with an ED that have a designated nurse, physician, or both who coordinates pediatric emergency care.
- Disaster Plan Resources – Program Goal: To increase the percent of hospitals with an ED that have a disaster plan that addresses the needs of children.
- Weigh and Record Children’s Weight in Kilograms – Program Goal: To increase the percent of hospitals with an ED that weigh and record children in kilograms.

The NPRP particularly focuses on weighing and recording children’s weight in kilograms to avoid medication errors. Product labeling for medications with weight-based dosing utilize the metric system. Converting from pounds to kilograms is an error-prone process and can double the number of dosing errors made. Pediatric and neonatal patients are at greater risk for adverse drug events because they are more vulnerable to the effects of an error.²¹

¹⁷ American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement--guidelines for care of children in the emergency department (Oct. 2009), available at <https://doi.org/10.1542/peds.2009-1807> (last visited Nov. 12, 2025).

¹⁸ *Id.*

¹⁹ The program is also used to improve emergency medical care for children in prehospital settings and to advance family partnerships and leadership in efforts to improve EMSC systems of care, see <https://www.grants.gov/search-results-detail/340371> (last visited Nov. 12, 2025).

²⁰ EMSC Innovation and Improvement Center, Performance Measures, available at <https://emscimprovement.center/programs/partnerships/performance-measures/> (last visited Nov. 12, 2025).

²¹ Emergency Nurses Association, *Weighing all Patients in Kilograms* (2020), available at <https://www.pedsnurses.org/assets/docs/Engage/Position-Statements/Weighing%20All%20Patients%20in%20Kilograms%20Final%20Web.pdf> see also National Coordinating Council for Medication Error Reporting and Prevention, *Recommendations to Weigh Patients and Document Metric Weights*

The National Pediatric Readiness Assessment

Emergency department performance is measured based on the NPRA,²² a voluntary survey accessed via invitation from the NPRP. The NPRP has conducted two nationwide assessments. The first NPRA occurred in 2013 and the second was in 2021. According to current Program plans, the expectation is that the NPRA will occur every five years, so the next assessment will be in 2026.²³

Not all hospitals choose to participate in the NPRA. Florida participation rates (58 percent) are below the national average (71 percent), and dropped from 2013 to 2021 (from 61 to 58 percent). Additionally, while over the national average, Florida hospital readiness scores dropped on average between 2013 (78) and 2021 (75).^{24, 25}

Florida Emergency Medical Services for Children State Partnership Program

The Florida Emergency Medical Services for Children (EMSC) State Partnership Program²⁶ (program) is a quality improvement initiative administered by the University of Florida College of Medicine — Jacksonville, and is funded by a state partnership grant from the national EMSC Program.²⁷ The purpose of the program is to expand and improve emergency medical services for children who need treatment for trauma or critical care by partnering with EDs, emergency medical service agencies, and disaster preparedness organizations to enhance pediatric readiness. The program provides outreach and information to hospital EDs to help improve their pediatric readiness by, among other things, increasing awareness of, and participation in, the NPRP Assessment.

III. Effect of Proposed Changes:

Section 1 amends s. 395.1012, F.S., to require each hospital with an emergency department (ED) to:

- Develop and implement policies and procedures for pediatric patient care in the ED which reflect evidence-based best practices relating to, at a minimum:

to Ensure Accurate Medication Dosing (Oct. 2018), available at <https://www.nccmerp.org/recommendations-weigh-patients-and-document-metric-weights-ensure-accurate-medication-dosing-adopted> (both last visited Nov. 12, 2025).

²² National Pediatric Readiness Project, Pediatric Readiness Assessment, available at https://www.pedsready.org/home_docs/PedsReady%20Survey-OA%20Assessment.pdf (last visited Nov. 12, 2025).

²³ Emergency Medical Services for Children, National Pediatric Readiness Project Assessment, available at <https://emscdatacenter.org/sp/pediatric-readiness/national-pediatric-readiness-project-nprp-assessment/> (last visited Nov. 12, 2025).

²⁴ Florida versus National Pediatric Readiness Project Results from 2013 Survey, available at <https://www.floridahealth.gov/provider-and-partner-resources/emsc-program/documents/fl-pediatricreadiness-summary091013.pdf> (last visited Nov. 12, 2025).

²⁵ Florida Versus National Pediatric Readiness Project Results from 2021 Survey, available at https://emlrc.org/wp-content/uploads/National-Pediatric-Readiness-Assessment-2021-Results_07.19.2023_Final.pdf (last visited Nov. 12, 2025).

²⁶ Florida Emergency Medical Services for Children State Partnership Program (Florida PEDREADY), available at <https://flemsc.emergency.med.jax.ufl.edu/> (last visited Nov. 12, 2025).

²⁷ EMSC Innovation and Improvement Center, EMSC State Partnership Grants Database, Florida – State Partnership, April 1, 2023 – March 31, 2027, available at <https://emscimprovement.center/programs/grants/236/florida-state-partnership-20230401-20270331-emsc-state-partnership/> (last visited Nov. 12, 2025).

- Triage.
- Measuring and recording vital signs.
- Weighing and recording weights in kilograms.
- Calculating medication dosages.
- Use of pediatric instruments.
- Conduct training at least annually on the policies and procedures developed for pediatric patient care in the ED. The training must include, at a minimum:
 - The use of pediatric instruments, as applicable to each licensure type, using clinical simulation as defined in s. 464.003, F.S.²⁸
 - Drills that simulate emergency situations. Each ED must conduct drills at least annually.
- Designate a pediatric emergency care coordinator. The pediatric emergency care coordinator must be a physician or a physician assistant licensed under ch. 458 or ch. 459, F.S., a nurse licensed under ch. 464, F.S., or a paramedic licensed under ch. 401, F.S. The pediatric emergency care coordinator is responsible for implementation of and ensuring fidelity to the policies and procedures adopted as required above.
- Conduct the NPRA developed by the NPRP, in accordance with timelines established by the NPRP. The bill also authorizes each hospital with an ED to conduct the NPRP's Open Assessment during a year in which the NPRA is not conducted.

Section 2 amends s. 395.1055, F.S., to require the AHCA to:

- Incorporate the needs of pediatric and neonatal patients in rules requiring an emergency management plan for hospitals and ambulatory surgical centers; and
- Adopt rules, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, that establish minimum standards for pediatric patient care in hospital EDs, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies.

Section 3 amends s. 408.05, F.S., to require the AHCA to:

- Collect the results of the NPRA from the Florida Emergency Medical Services for Children State Partnership Program by December 31, 2027, and each December 31 during a year in which the NPRA is conducted; and
- By April 1, 2028, and each April 1 following a year in which the NPRA is conducted, publish the overall assessment score for each hospital ED and provide a comparison to the national average score when it becomes available. The bill specifies that only one overall assessment score per hospital, per year, may be collected and published and the comparison must be to the most recently published score.

Section 4 provides that the bill takes effect July 1, 2026.

²⁸ Section 464.003(8), F.S., defines "clinical simulation" to mean a strategy used to replicate clinical practice as closely as possible to teach theory, assessment, technology, pharmacology, and skills.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

The bill will have an indeterminate, negative fiscal impact on hospitals related to incorporating additional requirements specific to pediatric readiness in the hospitals' emergency departments.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.1012, 395.1055, and 408.05.

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.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Harrell

31-00319-26

202668__

A bill to be entitled

An act relating to health care patient protection; amending s. 395.1012, F.S.; requiring hospitals with emergency departments to develop and implement policies and procedures and conduct training; requiring hospital emergency departments to designate a pediatric emergency care coordinator and conduct specified assessments; authorizing a hospital with an emergency department to conduct the National Pediatric Readiness Project's Open Assessment under certain circumstances; amending s. 395.1055, F.S.; requiring the Agency for Health Care Administration to adopt certain rules for comprehensive emergency management plans; requiring the agency, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, to adopt rules that establish minimum standards for pediatric patient care in hospital emergency departments; amending s. 408.05, F.S.; requiring the agency to collect and publish the results of specified assessments submitted by hospitals by specified dates; providing requirements for the collection and publication of the hospitals' assessment scores; providing an effective date.

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

Section 1. Subsections (6) and (7) are added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

31-00319-26

202668__

(6) (a) Each hospital with an emergency department shall:

1. Develop and implement policies and procedures for pediatric patient care in the emergency department which reflect evidence-based best practices relating to, at a minimum, all of the following:

a. Triage.

b. Measuring and recording vital signs.

c. Weighing and recording weights in kilograms.

d. Calculating medication dosages.

e. Use of pediatric instruments.

2. Conduct training at least annually on the policies and procedures developed under this subsection. The training must include, at a minimum:

a. The use of pediatric instruments, as applicable to each licensure type, using clinical simulation as defined in s. 464.003.

b. Drills that simulate emergency situations. Each emergency department must conduct drills at least annually.

(b) Each hospital emergency department shall:

1. Designate a pediatric emergency care coordinator. The pediatric emergency care coordinator must be a physician or a physician assistant licensed under chapter 458 or chapter 459, a nurse licensed under chapter 464, or a paramedic licensed under chapter 401. The pediatric emergency care coordinator is responsible for implementation of and ensuring adherence to the policies and procedures adopted under this subsection.

2. Conduct the National Pediatric Readiness Assessment developed by the National Pediatric Readiness Project, in accordance with timelines established by the National Pediatric

31-00319-26

202668__

Readiness Project.

(7) Each hospital with an emergency department may conduct the National Pediatric Readiness Project's Open Assessment during a year in which the National Pediatric Readiness Assessment is not conducted.

Section 2. Present subsections (4) through (19) of section 395.1055, Florida Statutes, are redesignated as subsections (5) through (20), respectively, a new subsection (4) is added to that section, and paragraph (c) of subsection (1) of that section is amended, to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(c) A comprehensive emergency management plan is prepared and updated annually. Such standards must be included in the rules adopted by the agency after consulting with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records;~~7~~ and responding to family inquiries and the needs of pediatric and neonatal patients. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the

31-00319-26

202668__

88 plan: the Department of Elderly Affairs, the Department of
89 Health, the Agency for Health Care Administration, and the
90 Division of Emergency Management. Also, appropriate volunteer
91 organizations must be given the opportunity to review the plan.
92 The local emergency management agency shall complete its review
93 within 60 days and either approve the plan or advise the
94 facility of necessary revisions.

95 (4) The agency, in consultation with the Florida Emergency
96 Medical Services for Children State Partnership Program, shall
97 adopt rules that establish minimum standards for pediatric
98 patient care in hospital emergency departments, including, but
99 not limited to, availability of and immediate access to
100 pediatric-specific equipment and supplies.

101 Section 3. Paragraph (n) is added to subsection (3) of
102 section 408.05, Florida Statutes, to read:

103 408.05 Florida Center for Health Information and
104 Transparency.—

105 (3) HEALTH INFORMATION TRANSPARENCY.—In order to
106 disseminate and facilitate the availability of comparable and
107 uniform health information, the agency shall perform the
108 following functions:

109 (n)1. Collect the overall assessment score of National
110 Pediatric Readiness Assessments conducted by hospital emergency
111 departments pursuant to s. 395.1012(6) from the Florida
112 Emergency Medical Services for Children State Partnership
113 Program by December 31, 2027, and by December 31 of each year in
114 which the National Pediatric Readiness Assessment is conducted
115 thereafter.

116 2. By April 1, 2028, and by April 1 following each year in

31-00319-26

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117 which the National Pediatric Readiness Assessment is conducted
118 thereafter, publish the overall assessment score for each
119 hospital emergency department and provide a comparison to the
120 national average score when it becomes available.

121 3. Collect and publish no more than one overall assessment
122 score per hospital, per year, of assessments conducted pursuant
123 to s. 395.1012(6) and provide a comparison to the hospital
124 emergency department's most recently published score pursuant to
125 subparagraph 2.

126 Section 4. This act shall take effect July 1, 2026.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR GAYLE HARRELL

31st District

November 10, 2025

Senate Colleen Burton, Chair
Senate Committee on Health Policy
530 Knott Bldg.
Tallahassee, FL 32399

Chair Burton,

I respectfully request Senate Bill 68 – Health Care Patient Protection be placed on the committee agenda at your earliest convenience.

Sincerely

A handwritten signature in blue ink that reads "Gayle B. Harrell".

Gayle Harrell, Senator

COMMITTEES:

Appropriations Committee on Higher
Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and
Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

JOINT COMMITTEE:

Joint Legislative Budget Commission

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- ☐ 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 154

INTRODUCER: Senator Harrell

SUBJECT: Mobile Opportunity by Interstate Licensure Endorsement Act

DATE: November 17, 2025

REVISED: _____

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

I. Summary:

SB 154 provides that out-of-state dentists and dental hygienists are ineligible for licensure under Florida's Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act if they did not graduate from a school accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association.

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

II. Present Situation:

Regulation of Dental Services

The Department of Health (DOH) is the state's primary public health agency, responsible for safeguarding the health and well-being of residents and visitors. The Division of Medical Quality Assurance (MQA) within the DOH has general regulatory authority over health care practitioners. The MQA works in conjunction with 22 regulatory boards and four councils to license and regulate over 1.5 million health care practitioners.¹ Professions are generally regulated by individual practice acts and by ch. 456, F.S., which provides regulatory and licensure authority for the MQA.

The Board of Dentistry (Board) is responsible for adopting rules to implement provisions of chapter 466, Florida Statutes, regulating the practice of dentists, dental hygienists, and dental assistants.² The Board consists of 11 members including seven licensed dentists actively practicing in the state, two licensed dental hygienists actively practicing in the state, and two

¹ Florida Department of Health, Division of Medical Quality Assurance, FY 2024–25 Annual Report and Long-Range Plan 24 (Oct. 31, 2025), <https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/documents/2025.10.31.FY24-25MQAAR-FINAL1.pdf> (last visited Nov. 12, 2025).

² Section 466.004(1), F.S.

laypersons.³ Members of the Board are appointed by the Governor and subject to confirmation by the Senate.⁴ Four seats are currently vacant.⁵ The Council on Dental Hygiene and Council on Dental Assisting advise the Board on rules and policies relating to their respective professions.⁶

Dentists and dental hygienists must receive specified education and training to become licensed and practice in their respective professions. Dental assistants may provide a narrow scope of services as authorized and supervised by a licensed dentist;⁷ however, dental assisting is an unlicensed profession. Two of the most prominent licensure pathways are licensure by endorsement and licensure by examination.

The DOH reports that 14,960 Florida licensed dentists and 16,899 dental hygienists were actively practicing in-state during state fiscal year 2024-25.⁸ During that time frame, the DOH issued initial licenses for 1,380 dentists and 1,767 dental hygienists;⁹ 291 dentists and 66 dental hygienists were licensed through the MOBILE Act.¹⁰

Licensure by Endorsement: The MOBILE Act

The Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act, codified in s. 456.0145, Florida Statutes, is a pathway for the expedited licensure of health care professionals who are licensed in good standing in the U.S. outside of the state of Florida. The Act was designed to facilitate workforce mobility and expand access to care by allowing eligible out-of-state practitioners to obtain licensure by endorsement in Florida without undergoing traditional initial licensure requirements, such as additional examinations or coursework.

To obtain Florida licensure by endorsement under the MOBILE Act, an applicant must:

- Submit a complete application and any required fees and documents.
- Maintain an active, unencumbered license from another U.S. state, territory, or Washington, D.C., in a profession with a similar scope of practice, as determined by the applicable board or the DOH if there is no board.
- Either have a passing score on a national licensure examination or hold a national certification recognized for the profession. If the profession has no national exam or certification, the applicable board, or the DOH if there is no board, must determine that the issuing jurisdiction's education (and, if applicable, exam/experience/supervision) requirements are substantially similar to Florida's.
- Have actively practiced the profession for at least two years in the four years immediately before applying.
- Attest that the applicant is not currently the subject of a disciplinary proceeding and has had no disciplinary action within the past five years.

³ *Id.*

⁴ *Id.*

⁵ Florida Board of Dentistry, *The Board*, <https://floridasdentistry.gov/the-board/> (last visited Nov. 12, 2025).

⁶ Section 466.004(2), F.S.

⁷ Section 466.024, F.S. Rule 64B5-16.005, F.A.C.

⁸ *Id.* at 24-25.

⁹ *Id.* at 35-36.

¹⁰ *Id.* at 42.

- Meet s. 456.048, F.S., or any profession-specific financial responsibility requirements, if applicable.
- Submit fingerprints for background screening under s. 456.0135, F.S., if required for the profession.

An applicant is ineligible for licensure by endorsement under the MOBILE Act if any of the following apply:

- The applicant has a pending complaint, allegation, or investigation.
- The applicant has been convicted of, or has pled nolo contendere to, any felony or misdemeanor related to the practice of health care.
- The applicant has had a license revoked, suspended, or surrendered in lieu of discipline.
- The applicant has been reported to the National Practitioner Data Bank for conduct that would constitute a violation of Florida law or rule, unless the report has been successfully removed through appeal.

For conduct reported to the National Practitioner Data Bank that would not constitute a violation of Florida law or rule, the applicable board, or the DOH if there is no board, may approve the application, approve with restrictions, approve on probationary status, or deny the application.

Licensure by Examination: Requirements for Dental Professionals

Licensure Requirements for Dentists

A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.¹¹ Dentists may delegate certain tasks¹² to dental hygienists and dental assistants, but a patient's "dentist of record" retains primary responsibility for all dental treatment on the patient.¹³

To be licensed as a dentist in Florida, a person must apply to the DOH and meet the following requirements:¹⁴

- Be at least 18 years of age;
- Be a graduate of a dental school accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association (ADA); or, if the applicant graduated from a nonaccredited dental school, present to the Board one of the following criteria:
 - Complete, at an accredited American dental school, a matriculated general dental program which consists of either four years of dental subjects or two years of predental education followed by three years of dental subjects and receive a receive a D.D.S. or D.M.D. from the institution at which the dental school is located; or
 - Complete two consecutive academic years at a full-time, matriculated Commission on Dental Accreditation of the American Dental Association accredited supplemental general dentistry program, which provides didactic and clinical education to the level of an accredited D.D.S. or D.M.D. program.

¹¹ Sections 466.003(2) and 466.003(3), F.S.

¹² Section 466.024, F.S.

¹³ Section 466.018, F.S.

¹⁴ Section 466.006, F.S.; Rule 64B5-2.0146, F.A.C.

- Obtain a passing score on the:
 - American Dental License Examination (ADEX), developed by the American Board of Dental Examiners, Inc.;
 - National Board of Dental Examiners Dental Examination (NBDE), administered by the Joint Commission on National Dental Examinations (JCNDE);¹⁵ and
 - A written examination on Florida laws and rules regulating the practice of dentistry.

Licensure Requirements for Dental Hygienists

A dental hygienist provides education, preventive, and delegated therapeutic dental services under varying levels of supervision by a licensed dentist.¹⁶ To be licensed as a dental hygienist, a person must apply to the DOH and meet the following requirements:¹⁷

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school; or for a graduate of a non-accredited dental hygiene college or school submits the following credentials for review by the Board:
 - Transcripts totaling four academic years of postsecondary dental education; and
 - A dental school diploma which is comparable to a D.D.S. or D.M.D.
- Obtain a passing score on the:
 - Dental Hygiene National Board Examination;
 - Dental Hygiene Licensing Examination developed by the American Board of Dental Examiners, Inc., which is graded by a Florida-licensed dentist or dental hygienist employed by the DOH for such purpose; and
 - A written examination on Florida laws and rules regulating the practice of dental hygiene.

Commission on Dental Accreditation (CODA)¹⁸

The Commission on Dental Accreditation (CODA) is the nationally recognized accrediting agency for dental and dental-related education programs in the United States. Established in 1975 and operating under the American Dental Association, CODA is recognized by the U.S. Department of Education as the sole accrediting body for dental education programs.

CODA accredits programs in general dentistry and advanced dental education, as well as allied dental professions, including dental hygiene, dental assisting, and dental laboratory technology. Accreditation by CODA is a voluntary process that assures the public and licensing boards that a program meets nationally accepted standards of quality. Institutions seeking CODA accreditation must demonstrate compliance with discipline-specific standards and are subject to site visits and ongoing evaluation. CODA accredits more than 1,400 programs in the United States.

¹⁵ American Dental Association, Joint Commission on National Dental Examinations, *Upholding Quality Oral Care For All*. Available at <https://jcnde.ada.org/> (last visited Nov. 12, 2025).

¹⁶ Sections 466.003(4), F.S., and 466.003(5), F.S.; Rule 64B5-2.0144, F.A.C.

¹⁷ Section 466.007, F.S.

¹⁸ Commission on Dental Accreditation, *About CODA*, American Dental Association, <https://coda.ada.org/about-coda> (last visited Nov. 12, 2025).

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 456.0145(2)(c), F.S., to revise the list of persons ineligible for licensure by endorsement under the MOBILE Act. The bill adds that an applicant seeking licensure to practice under ch. 466, F.S. (dentistry or dental hygiene) is ineligible for licensure by endorsement if the applicant has not graduated from a dental school or dental hygiene college or school accredited by the American Dental Association Commission on Dental Accreditation (CODA) or a comparable accrediting agency recognized by the United States Department of Education.

In effect, this would ensure that an out-of-state dentist or an out-of-state dental hygienist obtaining licensure by endorsement via the MOBILE Act meets the educational standards required of a dentist obtaining traditional licensure by examination in Florida. Out-of-state dentists and dental hygienists who have graduated from unaccredited schools may seek initial licensure by examination in Florida under the bill through existing pathways that generally require the Board to assess the applicant's proof of additional education on a case-by-case basis.

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

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following section 456.0145 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Harrell

31-00503-26

2026154__

A bill to be entitled
An act relating to the Mobile Opportunity by
Interstate Licensure Endorsement Act; amending s.
456.0145, F.S.; revising the list of persons
ineligible for a license by endorsement under the act;
providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section
456.0145, Florida Statutes, is amended to read:

456.0145 Mobile Opportunity by Interstate Licensure
Endorsement (MOBILE) Act.—

(2) LICENSURE BY ENDORSEMENT.—

(c) A person is ineligible for a license under this section
if he or she:

1. Has a complaint, an allegation, or an investigation
pending before a licensing entity in another state, the District
of Columbia, or a possession or territory of the United States;

2. Has been convicted of or pled nolo contendere to,
regardless of adjudication, any felony or misdemeanor related to
the practice of a health care profession;

3. Has had a health care provider license revoked or
suspended by another state, the District of Columbia, or a
territory of the United States, or has voluntarily surrendered
any such license in lieu of having disciplinary action taken
against the license; ~~or~~

4. Has been reported to the National Practitioner Data
Bank, unless the applicant has successfully appealed to have his

31-00503-26

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or her name removed from the data bank. If the reported adverse action was a result of conduct that would not constitute a violation of any law or rule in this state, the board, or the department if there is no board, may:

a. Approve the application;

b. Approve the application with restrictions on the scope of practice of the licensee;

c. Approve the application with placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department if there is no board, may specify, including, but not limited to, requiring the applicant to submit to treatment, attend continuing education courses, or submit to reexamination; or

d. Deny the application; or

5. Is seeking licensure to practice under chapter 466 and has not graduated from a dental school or dental hygiene college or school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental or dental hygiene program accrediting entity recognized by the United States Department of Education.

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



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR GAYLE HARRELL

31st District

November 10, 2025

Senate Colleen Burton, Chair
Senate Committee on Health Policy
530 Knott Bldg.
Tallahassee, FL 32399

Chair Burton,

I respectfully request Senate Bill 154 – Mobile Opportunity by Interstate Endorsement Act be placed on the committee agenda at your earliest convenience.

Sincerely

A handwritten signature in blue ink that reads "Gayle B. Harrell".

Gayle Harrell, Senator

COMMITTEES:

Appropriations Committee on Higher
Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and
Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

JOINT COMMITTEE:

Joint Legislative Budget Commission

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- ☐ 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 254

INTRODUCER: Senator Harrell

SUBJECT: Nursing Education Programs

DATE: November 17, 2025

REVISED: _____

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

I. Summary:

SB 254 revises regulatory oversight of prelicensure nursing education programs (programs) and creates a temporary provisional license for graduate nurses. The bill:

- Requires the Department of Health (DOH) to issue a nonrenewable temporary provisional license, valid for up to 180 days, to applicants eligible to take the National Council Licensure Examination (NCLEX). Temporary provisional licensees may practice as graduate registered nurses and graduate practical nurses under the direct supervision of a registered nurse or licensed practical nurse, as applicable, and the supervising nurse must file a protocol with the DOH.
- Beginning August 1, 2027, requires programs with NCLEX passage rates more than 10 percentage points below the national average for comparable U.S.-educated, first-time test takers, to offer a graduate nursing preceptorship and free remediation to graduates who fail the NCLEX after completing the preceptorship. Encourages all programs to offer three-month preceptorships, which may include job shadowing, supervised clinical and nonclinical training, and patient care in a hospital setting. Clinical preceptors must oversee the preceptorship. Graduates with temporary provisional licenses may participate and are expected to sit for the NCLEX at the conclusion of the preceptorship. Requires the Florida Center for Nursing to establish preceptorship standards by January 1, 2027, including supervision requirements. The Board of Nursing (BON) must adopt the standards by rule.
- Requires programs to implement standardized admissions criteria to identify students needing additional academic support and maintain individualized support plans for such students.
- Requires programs to administer a national, standardized, comprehensive exit examination to assess NCLEX readiness. Students may not be denied graduation based solely on exit examination results. Programs must submit remediation criteria to the BON for students who do not pass the examination.

- Requires the BON to deny approval of a new program, and authorizes the BON to revoke approval of an existing program, that has been subject to adverse action in another U.S. jurisdiction. Defines “adverse action” to include revocation, suspension, probation, or other encumbrances affecting the program’s authorization to operate.
- Requires program directors to submit annual reports to the BON and authorizes the BON to terminate programs for failure to comply, with a possible one-time, 60-day extension for good cause. Authorizes penalties against directors who fail to submit timely reports.
- Requires the DOH to report each program’s average NCLEX passage rate to its director, who must publish the rate on the program’s website. Requires the BON to publish passage rates for each program on its website.
- Requires approved programs placed on probation to submit and present a remediation plan with nationally recognized benchmarks within six months. Requires program termination and authorizes penalties against the program director for failure to comply.
- Eliminates the BON’s authority to extend probation for a third year.
- Authorizes DOH employees to conduct unannounced onsite inspections of approved or accredited programs to verify compliance or investigate violations. A program’s refusal to allow inspection constitutes a violation of legal obligations to the BON and DOH.
- Eliminates the BON’s authority to grant an extension for approved programs to obtain accreditation.

The bill will have a significant, negative fiscal impact on state expenditures. See Section V., Fiscal Impact Statement.

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

II. Present Situation:

Florida Postsecondary Nursing Education Programs

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

Post-licensure nursing programs advance the training of licensed RNs and include Registered Nurse to Bachelor of Science in Nursing (RN to BSN), Master of Science in Nursing (MSN), Doctor of Nursing Practice (DNP), Doctor of Philosophy (Ph.D.) programs, and nursing certificates. Upon completion of some master's and doctorate programs, RNs transition to an advanced practice registered nurse (APRN) license. These roles include nurse practitioner (NP),

¹ Department of Health, *Senate Bill 526 Legislative Analysis* (Feb. 28, 2025) (on file with the Senate Committee on Health Policy).

² Florida Center for Nursing (2025), *The State of Nursing Education in Florida - 2025*, Tampa, Fla., available at <https://issuu.com/flcenterfornursing/docs/newthestateofnursingeducationinflorida> (last visited Nov. 6, 2025).

certified nurse midwife (CNM), clinical nurse specialist (CNS), psychiatric mental health nurse practitioner, and certified registered nurse anesthetist (CRNA).³

Pre-licensure Nursing Education Programs

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

- For an RN education program, the program director and that at least 50 percent of the program's faculty members must be RNs who have a master's degree or higher in nursing or a bachelor's degree in nursing and a master's or higher degree in a field related to nursing;
- For an LPN education program, the program director and at least 50 percent of the program's faculty members must be RNs who have a bachelor's degree or higher in nursing;
- The program's nursing major curriculum consists of at least:
 - Fifty percent clinical training in the U.S., the District of Columbia (D.C.), or a possession or territory of the U.S. for an LPN, ARN, or a diploma RN;
 - Forty percent of clinical training in a U.S. state, D.C., or a possession or territory of the U.S. for a Bachelor of Science degree RN education program, and no more than 50 percent of the program's clinical training may consist of clinical simulation.
- The RN and LPN educational degree requirements may be documented by an official transcript or by a written statement from the educational institution verifying that the institution conferred the degree;
- The program must have signed agreements with each agency, facility, and organization included in the curriculum plan as clinical training sites and community-based clinical experience sites;
- The program must have written policies for faculty which include provisions for direct or indirect supervision by faculty or clinical preceptors for students in clinical training consistent with the following standards;
 - The number of program faculty members must equal at least one faculty member directly supervising every 12 students unless the written agreement between the program and the agency, facility, or organization providing clinical training sites allows more students, not to exceed 18, to be directly supervised by one program faculty member;
 - For a hospital setting, indirect supervision may occur only if there is direct supervision by an assigned clinical preceptor and a supervising program faculty member is available by telephone, and such arrangement is approved by the clinical facility;
 - For community-based clinical experiences that involve student participation in invasive or complex nursing activities, students must be directly supervised by a program faculty member or clinical preceptor and such arrangement must be approved by the community-based clinical facility;

³ *Id.*

⁴ Section. 464.019, F.S. and Florida Board of Nursing, *Education and Training Programs*, available at <https://floridasnursing.gov/education-and-training-programs/> (last visited Nov. 6, 2025).

⁵ Section 464.019(1), F.S.

- For community-based clinical experiences not involving student participation in invasive or complex nursing activities, indirect supervision may occur only when a supervising program faculty member is available to the student by telephone; and
- A program's clinical training policies must require that a clinical preceptor who is supervising students in an RN education program be an RN or, if supervising students in an LPN education program, be an RN or LPN.
- The RN or LPN nursing curriculum plan must document clinical experience and theoretical instruction in medical, surgical, obstetric, pediatric, and geriatric nursing. An RN curriculum plan must also document clinical experience and theoretical instruction in psychiatric nursing. Each curriculum plan must document clinical training experience in appropriate settings that include, but are not limited to, acute care, long-term care, and community settings;
- An RN or LPN education program must provide theoretical instruction and clinical application in the following:
 - Personal, family, and community health concepts;
 - Nutrition;
 - Human growth and development throughout the lifespan;
 - Body structure and function;
 - Interpersonal relationship skills;
 - Mental health concepts;
 - Pharmacology and administration of medications; and
 - Legal aspects of practice; and
- An RN nursing education program must also provide theoretical instruction and clinical experience in:
 - Interpersonal relationships and leadership skills;
 - Professional role and function; and
 - Health teaching and counseling skills.

Program Approval Process

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

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

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

- Approve the application; or

⁶ Sections 464.019(2) and 464.003(4), F.S.

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

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

Approved Nursing Pre-licensure Education Programs Annual Report

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

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

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

Approved Nursing Pre-licensure Education Programs Accountability

Graduate Passage Rates

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

⁷ *Id.*

⁸ *Id.*

⁹ Section 464.019(3), F.S.

¹⁰ Section 464.019(5), F.S.

¹¹ Section 464.019(5), F.S.

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

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

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

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

If the program, during the two calendar years following its placement on probation, does not achieve the required passage rate for any one calendar year, the BON may extend the program's probationary status for one additional year if certain criteria are met. If the program is not granted the one-year extension or fails to achieve the required passage rate by the end of the extension, the BON must terminate the program. If students from a program that is terminated transfer to an approved or accredited program under the direction of the Commission for Independent Education, the BON must recalculate the passage rates of the programs receiving the transfer students and exclude the test scores of those students transferring more than 12-credits.¹⁴

An "accredited" nursing education program is a program for the pre-licensure education of RNs or LPNs that is conducted at a U.S. educational institution, whether in Florida, another state, or D.C., and that is accredited by a specialized nursing accrediting agency that is nationally recognized by the U.S. Secretary of Education to accredit nursing education programs.¹⁵

¹² *Id.*

¹³ *Id.*

¹⁴ Section 464.019(5), F.S.

¹⁵ Section 464.003(1), F.S. Eligible institutional and accrediting Agencies available to Florida Nursing Programs are: Accreditation Commission for Education in Nursing (ACEN), Inc., formerly, National League for Nursing Accrediting Commission; Commission on Collegiate Nursing Education (CCNE)); National League for Nursing Commission for Nursing Education Accreditation (NLN CNEA); National Nurse Practitioner Residency and Fellowship Training Consortium; and Florida Board of Nursing, *See* U.S. Department of Education, Accreditation in the U.S., available at https://www.ed.gov/laws-and-policy/higher-education-laws-and-policy/college-accreditation/college-accreditation-united-states/college-accreditation-in-the-united-states--pg-4#National_Institutional#National_Institutional (last visited Nov. 6, 2025); and Florida Board of Nursing, *What is the difference between an "approved" and an "accredited" pre-licensure nursing education program in Florida?* available at <https://floridasnursing.gov/help-center/what-is-the-difference-between-an-approved-and-an-accredited-pre-licensure-nursing-education-program-in-florida/> (last visited Nov. 6, 2025).

Accredited programs do not have to meet requirements related to program application, approval, or submission of annual reports to the BON.¹⁶

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

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

Board of Nursing Rulemaking Authority

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

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

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

III. Effect of Proposed Changes:

Temporary Provisional Licenses

Section 1 of the bill amends s. 464.008, F.S., to create a temporary provisional license. The Department of Health (DOH) must issue a temporary provisional license to any applicant who is eligible to sit for the National Council of State Boards of Nursing Licensing Examination (NCLEX) exam and seeks to practice as a graduate registered nurse or graduate practical nurse.²⁴

¹⁶ Section 464.019(9), F.S.

¹⁷ Excluded institutions are those exempt from licensure by the Commission of Independent Education under ss. 1005.06(1) and 464.019(11)(d), F.S.

¹⁸ Section 464.019(11)(a)-(d), F.S.

¹⁹ *Id.*

²⁰ Section 464.019(9)(b), F.S.

²¹ Section 464.019(8), F.S.

²² *Id.*

²³ Section 464.019(8), F.S.

²⁴ Pursuant to subsection (1) of that section, the DOH must examine each applicant who has submitted an application, the required fees, and the cost of the examination; has passed an FDLE criminal history record check; is a high school graduate in good mental health; has graduated from a nursing program; and can communicate in English.

The license is valid for up to 180 days, nonrenewable, and automatically expires when the applicant passes the exam and is issued a full license or fails the exam. A temporary provisional licensee may practice only under direct supervision of an RN or LPN, as applicable, and the supervising nurse must file a written protocol with the DOH. The Board of Nursing (BON) must adopt rules to implement the supervision requirements.

Section 2 of the bill amends s. 464.019, F.S., revising the regulatory oversight of prelicensure nursing education programs.

Application Requirements

The bill requires that a program application must include the legal name of the nursing education program director and requires the program director to certify the accuracy of faculty credentials reported to the BON.

Admissions Criteria

The bill requires professional and practical nursing education programs to implement standardized admissions criteria that identify students who may require additional academic preparation and support to succeed. For each such student, the program must maintain documentation of an individualized academic support plan.

Exit Examinations

The bill also requires programs to administer a national, standardized, and comprehensive exit examination to assess students' readiness for the NCLEX. A student may not be denied graduation solely on the basis of the exit examination if all required coursework has been completed. Each program must submit established remediation criteria to the BON that it will offer to students who do not pass the exit examination.

Graduate Nursing Preceptorships Programs

Beginning August 1, 2027, any nursing education program with an annual NCLEX passage rate that is more than 10 percentage points below the average national passage rate for United States-educated, first-time test takers in comparable degree programs, must offer a graduate nursing preceptorship to its graduates. A graduate who does not pass the NCLEX at the conclusion of the preceptorship must be offered free remediation by the program.

Although preceptorships are required only for underperforming programs, all nursing programs are encouraged to offer them. A graduate nursing preceptorship must last three months and may include job shadowing, supervised clinical and nonclinical training, and patient care in a hospital setting. Clinical preceptors must oversee the preceptorship.

Graduates who hold a temporary provisional license under s. 464.008(5), F.S., may participate in a preceptorship. These graduates are expected to sit for the NCLEX at the conclusion of the preceptorship.

By January 1, 2027, the Florida Center for Nursing must establish standards for graduate nursing preceptorships, including supervision requirements. The BON is required to adopt these standards by rule.

Programs Facing Adverse Actions in Other Jurisdictions

The bill requires the BON to deny an application from a nursing education program that has had adverse action taken against it by another regulatory jurisdiction in the U.S. The BON may also revoke the approval of an existing approved program that has had adverse action taken against it by another regulatory jurisdiction in the U.S. The term “adverse action” is defined as any administrative, civil, or criminal action imposed by a licensing board or other state authority against a nursing education program. The term includes actions such as revocation, suspension, probation, or any other encumbrances affecting the program’s authorization to operate.

Annual Reporting

The bill provides that the program director is responsible for submitting the annual report to the BON. The bill authorizes the BON to terminate a program for not submitting its annual report; however, the BON may give an extension of time, not to exceed 60 days, for a program’s submission of its annual report, upon request and for good cause. If a program director fails to timely submit the program’s annual report, the BON may impose a penalty listed in s. 456.072(2), F.S., against the program director.

Transparency of Passage Rates

The bill requires the DOH to report a program’s average NCLEX passage rate to the program director. The program director must publish the average passage rate on the program’s website. The bill also requires the BON to publish NCLEX passage rates for each individual nursing program on its website.

Program Remediation

For an approved program that is placed on probation, the bill requires the program director to submit to the BON a written remediation plan with specific nationally-recognized benchmarks to identify progress toward a graduate passage rate goal, and to present that plan to the BON. If the program director fails to submit the required written remediation plan, or fails to appear before the BON to present the remediation plan no later than six months after the date of the program being placed on probation, the bill requires the BON to terminate the nursing education program and authorizes the BON to impose a penalty listed in s. 456.072(2), F.S., against the program director. The bill removes the BON’s authority to extend an approved program’s probationary status for a third year.

Onsite Inspections

The bill authorizes agents or employees of the DOH to conduct onsite evaluations or inspections at any time during business hours to ensure that approved programs or accredited programs are in full compliance with ch. 464, F.S., or to determine whether ch. 464, F.S., or s. 456.072, F.S., is being violated. The DOH may collect any evidence necessary or as required to ensure

compliance with ch. 464, F.S. or for prosecution. A refusal by a nursing education program to allow an onsite evaluation or inspection is deemed a violation of a legal obligation imposed by the BON and the DOH.

Program Accreditation Deadline

The bill repeals s. 464.019(11)(f), F.S., which gives the BON authority to grant an extension of up to two years for an approved program to become accredited. This repeal eliminates any extension of the accreditation deadline. An approved program must become an accredited program within five years after the date of enrolling its first students.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill will have an indeterminate negative fiscal impact on the DOH. The bill requires the DOH to issue temporary provisional licenses that it currently does not issue to certain

nursing graduates as an optional first step before the graduate obtains full licensure. The bill also requires the DOH to calculate the average passage rate for graduates from each program on an ongoing basis.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 464.008, and 464.019.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Harrell

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A bill to be entitled

An act relating to nursing education programs; amending s. 464.008, F.S.; requiring the Department of Health to issue temporary provisional licenses to graduate registered nurses and graduate licensed practical nurses; providing requirements for the temporary provisional license; establishing that such graduate nurses may practice only under direct supervision and subject to a written protocol with a registered nurse or licensed practical nurse, as applicable; requiring the Board of Nursing to adopt rules; amending s. 464.019, F.S.; revising application requirements for nursing education program approval; specifying preceptorship requirements; requiring the Florida Center for Nursing to develop graduate nursing preceptorship standards by a specified date; requiring the board to incorporate the standards into rule; requiring the board to deny a program's application under certain circumstances; authorizing the board to revoke an existing program's approval under certain circumstances; defining the term "adverse action"; clarifying that an approved program's director is responsible for submitting certain annual reports to the board; requiring the board to terminate a program under certain circumstances; providing penalties for program directors found to be in violation of specified provisions; clarifying that the board must publish the graduate average passage rate of each approved nursing program on its website; revising

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remediation procedures for approved programs with graduate passage rates that do not meet specified requirements; subjecting program directors of approved programs to specified disciplinary action under certain circumstances; deleting a provision authorizing the board to extend a program's probationary status; authorizing agents or employees of the department to conduct onsite evaluations and inspections of approved and accredited nursing education programs; authorizing the department to collect evidence as part of such evaluations and inspections; deeming the failure or refusal of a program to allow such evaluation or inspection a violation of a legal obligation; requiring the department to disclose graduate average passage rates to each program director; requiring program directors to ensure that graduate average passage rates are posted on their program's website; revising rulemaking authority of the board; deleting a provision authorizing approved nursing education programs to request an extension to meet the board's accreditation requirements; providing an effective date.

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

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

464.008 Licensure by examination.—

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(1) Any person desiring to be licensed as a registered nurse or licensed practical nurse shall apply to the department to take the licensure examination. The department shall examine each applicant who:

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

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

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

1. Graduation from an approved program;
2. Graduation from a prelicensure nursing education program that the board determines is equivalent to an approved program;
3. Graduation on or after July 1, 2009, from an accredited program; or
4. Graduation before July 1, 2009, from a prelicensure nursing education program whose graduates at that time were eligible for examination.

Courses successfully completed in a professional nursing education program that are at least equivalent to a practical nursing education program may be used to satisfy the education

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requirements for licensure as a licensed practical nurse.

(d) Has the ability to communicate in the English language, which may be determined by an examination given by the department.

(5) (a) The department shall issue a temporary provisional license to an applicant who is eligible to take the licensure examination under subsection (1) and who seeks to practice as a graduate registered nurse or licensed practical nurse, as applicable.

(b) A temporary provisional license issued under this subsection:

1. Is valid for a period not to exceed 180 days after the date of issuance.

2. Is nonrenewable.

3. Automatically expires upon the applicant passing the licensure examination and the department issuing of a full license, or upon the applicant's failure to pass the examination.

(c) A temporary provisional licensee may practice only under the direct supervision of a registered nurse or licensed practical nurse, as applicable, who has filed a written protocol with the department. The board shall adopt rules to implement this paragraph.

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

464.019 Approval of nursing education programs.—

(1) PROGRAM APPLICATION.—An educational institution that wishes to conduct a program in this state for the prelicensure

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

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

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

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

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

1. Fifty percent clinical training in the United States, the District of Columbia, or a possession or territory of the

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146 United States for a practical nursing education program, an
147 associate degree professional nursing education program, or a
148 professional diploma nursing education program.

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

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

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

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

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

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

174 3. For community-based clinical experiences that involve

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175 student participation in invasive or complex nursing activities,
176 students must be directly supervised by a program faculty member
177 or clinical preceptor and such arrangement must be approved by
178 the community-based clinical facility.

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

183
184 A program's policies established under this paragraph must
185 require that a clinical preceptor who is supervising students in
186 a professional nursing education program be a registered nurse
187 or, if supervising students in a practical nursing education
188 program, be a registered nurse or licensed practical nurse.

189 (f) The professional or practical nursing curriculum plan
190 documents clinical experience and theoretical instruction in
191 medical, surgical, obstetric, pediatric, and geriatric nursing.
192 A professional nursing curriculum plan must ~~shall~~ also document
193 clinical experience and theoretical instruction in psychiatric
194 nursing. Each curriculum plan must document clinical training
195 experience in appropriate settings that include, but are not
196 limited to, acute care, long-term care, and community settings.

197 (g) The professional or practical nursing education program
198 provides theoretical instruction and clinical application in
199 personal, family, and community health concepts; nutrition;
200 human growth and development throughout the life span; body
201 structure and function; interpersonal relationship skills;
202 mental health concepts; pharmacology and administration of
203 medications; and legal aspects of practice. A professional

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nursing education program must also provide theoretical instruction and clinical application in interpersonal relationships and leadership skills; professional role and function; and health teaching and counseling skills.

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

(i) For each student, the professional or practical nursing education program administers an exit examination that is a national, standardized, and comprehensive predictor exam designed to help nursing students assess their readiness for the National Council of State Boards of Nursing Licensing Examination (NCLEX) by identifying areas needing further study and remediation. A student may not be excluded from graduation on the sole basis of the exit examination if the student has otherwise successfully completed all coursework required by the program.

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

(k) Beginning August 1, 2027, a program with a passage rate more than 10 percentage points lower than the average national passage rate during the same calendar year for graduates of

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comparable degree programs who are United States-educated, first-time test takers on the NCLEX, as calculated by the contract testing service of the National Council of State Boards of Nursing, offers a graduate nursing preceptorship to its graduates. If a graduate from such a program does not pass the NCLEX at the conclusion of his or her preceptorship, the professional or practical nursing education program must offer remediation to the graduate for free.

1. All programs are encouraged to offer a graduate nursing preceptorship to their graduates to provide opportunities for job shadowing, clinical training, nonclinical training, and patient care in a hospital setting. Graduates who have been issued a temporary provisional license under s. 464.008(5) may participate in such preceptorships. A graduate nursing preceptorship must last for 3 months, with the expectation that graduates will take the NCLEX at the conclusion of the preceptorship. Clinical preceptors shall oversee the preceptorship programs.

2. By January 1, 2027, the Florida Center for Nursing shall establish standards for graduate nursing preceptorships, including supervision requirements. The board shall incorporate the standards into rule.

(2) PROGRAM APPROVAL.—

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

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complete upon the department's receipt of:

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

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

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

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

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

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

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

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

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

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

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

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

317
318 The board must terminate the program pursuant to chapter 120 if
319 the requirements of this subsection are not met. Upon request,

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the board may give an extension for good cause not to exceed 60 days for a program to meet the requirements of this subsection. If a program director is found to be in violation of this subsection, the board may impose a penalty listed in s. 456.072(2).

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

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

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

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

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

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

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

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

4. The program's probationary status.

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

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

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

359
360 The information required to be published under this subsection
361 shall be made available in a manner that allows interactive
362 searches and comparisons of individual programs selected by the
363 website user. The board shall update the Internet website at
364 least quarterly with the available information.

365 (5) ACCOUNTABILITY.—

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

377 a. Professional nursing education programs that terminate

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in a bachelor's degree.

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

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

d. Practical nursing education programs.

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

3. Upon the program's achievement of a graduate passage rate that equals or exceeds the required passage rate, the

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

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

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

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status on the students or applicants.

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

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

(6) DISCLOSURE OF GRADUATE PASSAGE RATE DATA.—

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

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~~information is requested.~~

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

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

(8) RULEMAKING.—The board does not have rulemaking authority to administer this section, except that the board shall adopt rules that prescribe the format for submitting program applications under subsection (1) and annual reports under subsection (3), to implement graduate nursing preceptorships as established in paragraph (1)(k), to enforce and administer subsection (5), and to administer the documentation of the accreditation of nursing education programs under subsection (11). The board may adopt rules relating to the nursing curriculum, including rules relating to the uses and limitations of simulation technology, ~~and rules relating to the criteria to qualify for an extension of time to meet the accreditation requirements under paragraph (11)(f).~~ The board may not impose any condition or requirement on an educational institution submitting a program application, an approved program, or an accredited program, except as expressly provided in this section.

(11) ACCREDITATION REQUIRED.—

~~(f) An approved nursing education program may, no sooner~~

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~~than 90 days before the deadline for meeting the accreditation requirements of this subsection, apply to the board for an extension of the accreditation deadline for a period which does not exceed 2 years. An additional extension may not be granted. In order to be eligible for the extension, the approved program must establish that it has a graduate passage rate of 60 percent or higher on the National Council of State Boards of Nursing Licensing Examination for the most recent calendar year and must meet a majority of the board's additional criteria, including, but not limited to, all of the following:~~

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

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

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

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

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

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

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



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR GAYLE HARRELL

31st District

November 10, 2025

Senate Colleen Burton, Chair
Senate Committee on Health Policy
530 Knott Bldg.
Tallahassee, FL 32399

Chair Burton,

I respectfully request Senate Bill 254 – Nurse Education Program be placed on the committee agenda at your earliest convenience.

Sincerely

A handwritten signature in blue ink that reads "Gayle B. Harrell".

Gayle Harrell, Senator

COMMITTEES:

Appropriations Committee on Higher
Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and
Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

JOINT COMMITTEE:

Joint Legislative Budget Commission

REPLY TO:

- ☐ 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
- ☐ 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

Health Care Compacts

Presentation to the Senate Committee on Health Policy

Wendy Scott, Staff Director for Health and Human Services



OPPAGA

Office of Program Policy Analysis and Government Accountability

NOVEMBER 18, 2025

Project Scope and Methodology

As directed by the Legislature, OPPAGA examined the advantages and disadvantages of participation in health care compacts and answered three questions.

1. How does Florida reduce barriers for out-of-state practitioners to become licensed to practice in the state?
2. What are the advantages and disadvantages of joining health care compacts?
3. What are key considerations when contemplating participation in health care compacts?

Methodology

Information
and Data
Requests

Assessment of
Stakeholder
Perspectives

Literature
Review

Compact
Document
Review

Practice Avenues



Florida offers three options for licensed out-of-state practitioners to provide services in Florida



Licensure by Endorsement



Telehealth Registration

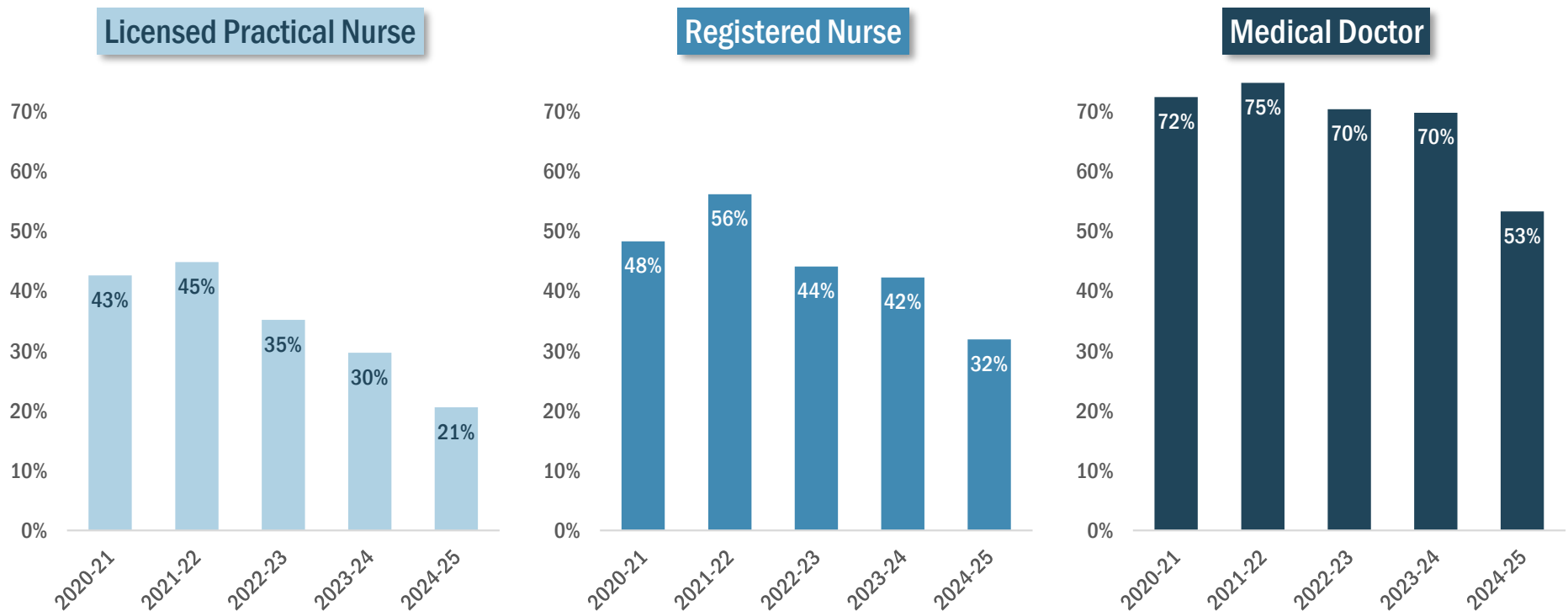


Licensure by Compact

Licensure by Endorsement



The percentage of out-of-state practitioners licensed by endorsement in each fiscal year has generally declined



Source: OPPAGA analysis of data from the Florida Department of Health.

Telehealth Registration



New telehealth registrations for out-of-state practitioners have remained relatively stable; more out-of-state physicians than nurses are registered to provide telehealth in Florida

- Section 456.47(4), *Florida Statutes*, authorizes practitioners located and licensed in other states to register with DOH to perform telehealth services for patients in Florida

Telehealth Profession	Fiscal Year				
	2020-21	2021-22	2022-23	2023-24	2024-25
Licensed Practical Nurse	1	1	3	1	0
Registered Nurse	9	41	16	25	23
Medical Doctor	1,225	2,705	1,282	1,042	1,054
Osteopathic Physician	115	254	172	172	149
Total New Registrations	1,350	3,001	1,473	1,240	1,226

Source: OPPAGA analysis of data from the Florida Department of Health.

Licensure by Compact



Health care compacts are legislatively enacted agreements between states to mutually recognize each state's practitioner licenses

State officials
form an advisory
body

A drafting team
develops model
legislation for
feedback

When model
legislation is
finalized, states
may adopt it

When a pre-set
number of states
adopt model
legislation,
commissions
form and
administer the
compact

States
implement
compact
legislation

States process
compact
applications

Florida Landscape



There are 17 health care compacts; Florida has passed legislation to join six and three are active



Active in Florida



2018: Nurse Licensure



2023: Psychology Interjurisdictional



2024: Interstate Medical Licensure



Not Yet Active in Florida



Counseling



Audiology and Speech-Language Pathology



Physical Therapy

Health Care Compacts Florida Has Not Joined



Advanced Practice Registered Nurse



Athletic Trainers



Dentist and Dental Hygienist



Dietician Licensure



Emergency Medical Services



Interstate Compact for School Psychologists



Interstate Massage Therapy



Occupational Therapy



Physician Assistant Licensure



Respiratory Care

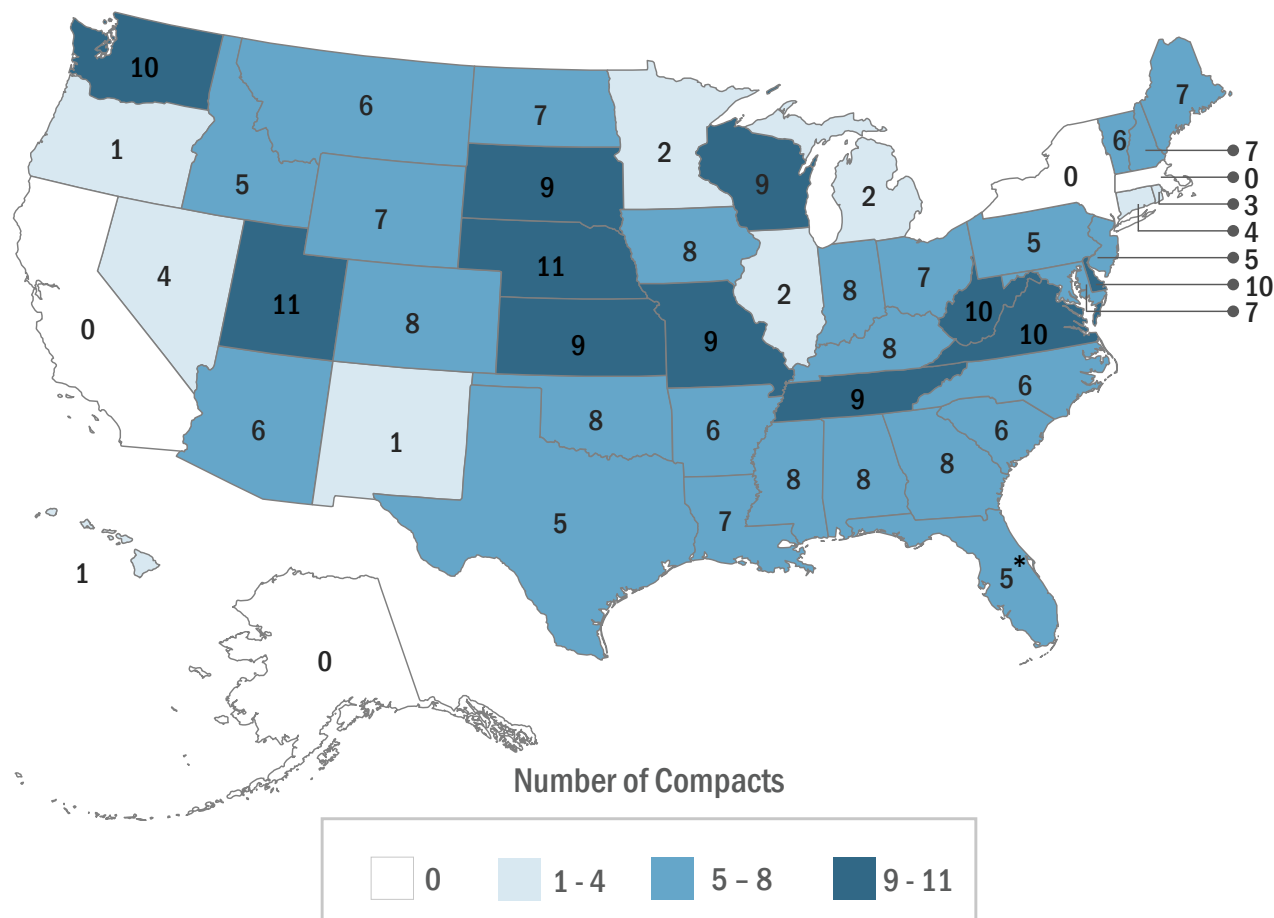


Social Work Licensure

National Landscape



Most states have joined between five and eight health care compacts



* This map excludes the Physical Therapy Compact from the count of Florida's compacts.

Source: OPPAGA analysis of data from Bogulski, Cari A., et al. "Trends in U.S. State and Territory Participation in Interstate Healthcare Licensure Compacts (2015-2024)." *Journal of Medical Regulation* 111.1 (2025): 8-25. <https://doi.org/10.30770/2572-1852-111.1.8>

Advantages and Disadvantages of Compacts



Health care compacts have reported advantages for the state, practitioners, and the public; some may have disadvantages



Compact Advantages

- Facilitates licensure and disciplinary data sharing
- Can expedite practitioner supply during certain circumstances, such as natural disasters
- Eases application requirements for practitioners
- Benefits military families
- Allows for continuity of care



Compact Disadvantages

- Cost and operational challenges
- May alter state scope of practice

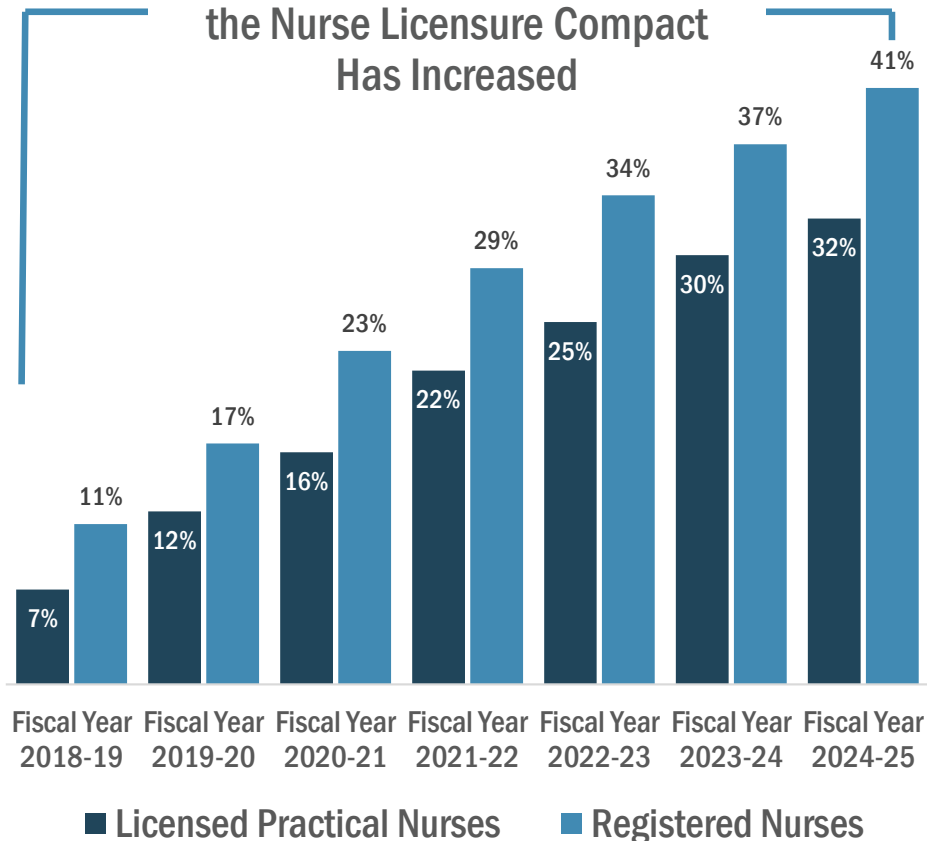
OPPAGA did not find reliable evidence to support claims that health care compacts reduce workforce shortages and increase access to providers

Nurse and Psychologist Compact Participation



Participation in health care compacts by Florida licensed practitioners varies; lack of reporting requirements results in inability to determine number of compact practitioners practicing in compact states

Florida Nurses' Participation in the Nurse Licensure Compact Has Increased



Some Florida Psychologists Have Joined the Psychology Compact



15.6% (1,235) of psychologists can practice telepsychology in other states



0.8% (66) can practice temporary in-person psychology in other states

Data Limitation

OPPAGA was unable to determine the number of compact nurses or psychologists from other states that practice in Florida and the number of Florida licensees that use their license to practice in other states.

Physician Compact Participation



Few Florida medical doctors and osteopathic physicians have been licensed through the Interstate Medical Licensure Compact (IMLC)

Physicians Seeking a Compact License in Fiscal Year 2024-25	Compact Licensed Medical Doctors	Compact Licensed Osteopathic Physicians
Florida physicians seeking a license in other states	1,225 (1.2%)	187 (1.3%)
Other state physicians seeking a license in Florida	1,005	163

Data Limitation

- The IMLC requires licensees to obtain a license in each state where they want the ability to practice.
- However, licensees are not required to report where they actually practice.
- As a result, OPPAGA could not determine whether Florida physicians use their compact license to practice in another state or whether physicians from other states use their compact license to practice in Florida.

Proposed Compacts



Of the 11 health care compacts that Florida has not joined, the Legislature proposed legislation to join three compacts

Compact	Proposed or Not Considered	Compact Accepting Applications? *
Interstate Compact for School Psychologists	2025 House Bill 327 proposed joining	No
Occupational Therapy Licensure	2025 House Bill 909 proposed joining	No
Social Work Licensure	2025 House Bill 27 proposed joining	No
Advanced Practice Registered Nurse	Not considered	No
Athletic Trainer	Not considered	No
Dentist and Dental Hygienist	Not considered	No
Dietician Licensure	Not considered	No
Emergency Medical Services	Not considered	Yes
Massage Therapist	Not considered	No
Physician Assistant Licensure	Not considered	No
Respiratory Care	Not considered	No

* Compacts may not be accepting applications because the required number of states have not enacted compact legislation; the compact commission has not yet formed; or the compact commission is developing data systems and bylaws.

Key Considerations



If contemplating joining additional health care compacts, the Legislature should focus on key compact provisions

Shared Provisions

- ✓ Public safety
- ✓ Quality of care
- ✓ Licensure portability
- ✓ Administrative efficiencies



Compacts may conflict with state practice laws

Florida Law

- APRNs must practice under a supervisory agreement with a physician

APRN Compact

- Requires that APRNs comply with the state practice laws of the state where the client is located
- Excludes state laws, rules, or regulations that require supervision from its definition of state practice laws

Key Considerations



The Legislature may also need to consider allocating resources to implement health care compacts; Florida may lose licensing revenue

Costs of State Participation



Compact commissions can collect an annual assessment from each participating state



Florida has paid \$6,000 annually for Nurse Licensure Compact membership since Fiscal Year 2019-20



Florida has paid \$6,000 annually for Psychology Compact membership since Fiscal Year 2023-24



States may need to hire additional staff and invest in technology to implement compacts

Potential Loss of Revenue



Licensing revenue is a major source of funds to support health care practitioner regulation



Some compacts do not have provisions that would allow Florida to charge out-of-state compact practitioners a fee for a multistate license

Contact Information

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FLORIDA LEGISLATURE OFFICE OF PROGRAM POLICY ANALYSIS AND
GOVERNMENT ACCOUNTABILITY

OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations.

Health Care Compacts

November 14, 2025



OPPAGA

Office of Program Policy Analysis and Government Accountability

EXECUTIVE SUMMARY

Occupational licensing for health care professions establishes minimum educational, training, and experience requirements to protect public safety. However, licensing may also create barriers to entering professions, and because each state may have different requirements, reduce geographic mobility in licensed professions. Research suggests that best practices to reduce licensure barriers include promoting licensure reciprocity and aligning license requirements across states, which can be accomplished by joining health care interstate licensure compacts. These legally enacted agreements between two or more states mutually recognize each state's practitioner licenses.

In general, health care compacts are intended to increase access to care and promote practitioner mobility. There are 17 compacts for a variety of health care professions. Health care compacts are developed at the national level with state input and can be characterized as either a mutual recognition model or an expedited licensure model. The mutual recognition model allows a practitioner to practice in other states using their home state license. The expedited licensure model requires applicants to obtain a license from each state where they intend to practice, using a more efficient and centralized application process through the compact.

Florida has passed legislation to join health care compacts for six professions—audiology and speech-language pathologists; counselors; physicians; nurses; physical therapists; and psychologists. Of these, Florida is currently active in three compacts (Nurse Licensure, Psychology, and Interstate Medical Licensure) and anticipates becoming active in two additional compacts (Audiology and Speech-Language Pathology and Counseling) by March 2026. Florida is currently ineligible to participate in the Physical Therapy Compact due to deviation from the required model legislation language.

Health care compacts have several advantages and disadvantages that vary across compact models. Stakeholders reported that advantages include sharing disciplinary data among states and making obtaining a license for multiple states easier. Additional advantages for practitioners are licensure portability, application ease, and for some compacts, streamlined continuing education requirements and lower licensure costs across multiple states. Disadvantages include costs, operational challenges, and potential conflict with existing state law. While some stakeholders reported that health care compacts increase a state's supply of practitioners, OPPAGA found limited reliable research evaluating the effect of compacts on state labor supply or labor mobility. In addition, while Florida's participation in the Nurse Licensure Compact included 32% of licensed practical nurses and 41% of registered nurses in Fiscal Year 2024-25, few Florida psychologists and physicians have joined their respective compacts.

If contemplating Florida's participation in additional health care compacts, the Legislature should focus on key compact provisions related to public safety, quality of care, licensure portability, and administrative efficiencies and should also consider financial and operational characteristics necessary for compact implementation.

REPORT SCOPE

As directed by the Legislature, OPPAGA examined the advantages and disadvantages of participation in health care compacts and answered three questions.

1. How does Florida reduce barriers for out-of-state practitioners to become licensed to practice in the state?
2. What are the advantages and disadvantages of joining health care compacts?
3. What are key considerations when contemplating participation in health care compacts?

BACKGROUND

Occupational licensing establishes minimum educational, training, and experience requirements to protect public safety

Occupational licensure is a regulatory method that requires people to secure a license from the government to practice a certain trade or profession. Licensing laws and regulations are established independently by each state legislature.¹ State laws and regulations may specify the requirements for obtaining a license (e.g., education, training, and experience requirements; licensure examinations; and licensure fees). State legislatures establish occupational licensing laws and regulations to specify requirements that must be met to practice in a licensed profession. Some states authorize state agencies to establish occupational licensing requirements. In other states, boards may perform these duties.

In general, there are benefits of occupational licensing, such as enhanced public safety due to minimum educational, training, and experience requirements for licensure. However, occupational licensing may also create barriers to entering professions and reduce employment and geographic mobility in licensed professions. Research suggests that best practices to reduce licensure barriers include promoting licensure reciprocity and aligning license requirements across states, which can be accomplished by joining health care interstate licensure compacts, legally enacted agreements between two or more states to mutually recognize each state's practitioner licenses.

Health care interstate licensure compacts may increase access to care and reduce occupational licensure barriers

Health care compacts are legislatively enacted agreements between two or more states to mutually recognize each state's practitioner licenses. There are 17 compacts for a variety of health care professions. In general, health care compacts are created to increase access to care by expanding practitioner mobility and reducing barriers to licensure, such as duplicative licensure processes. Health care compacts are developed at the national level with state input and can be characterized as either a mutual recognition model or an expedited licensure model.

Compacts are intended to increase access to care and promote interstate practitioner mobility

- A **member state** is a state that has enacted the compact.
- A **home state** is the member state that is the licensee's primary residence.
- A **remote state** is a member state, other than the home state, where a licensee is exercising or seeking to exercise compact authorization.

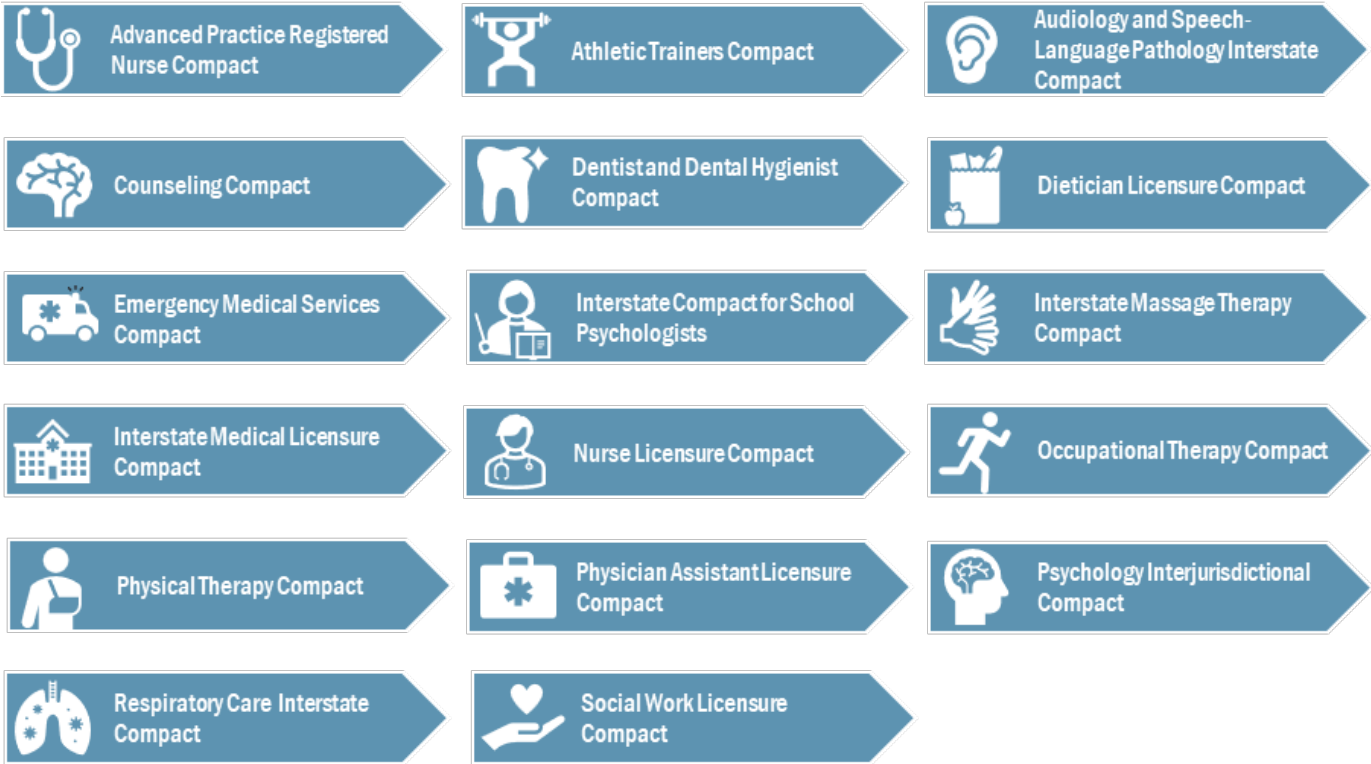
Health care compacts are legislatively enacted agreements between two or more states to mutually recognize each state's practitioner licenses. Health care compacts generally allow health care practitioners to practice in more than one state through a multi-state license via a compact (i.e., compact license) without obtaining separate licenses in each state. The practitioner must already hold or be eligible to hold a license in a state that participates in the compact and meet eligibility criteria that differs by

¹ The Tenth Amendment of the U.S. Constitution reserved for the states those powers not explicitly assigned to the federal government, including occupational licensing. It also authorized states to establish laws and regulations protecting the health, safety, and general welfare of citizens.

compact but may include not having a criminal history, meeting educational requirements, and having passed a national standardized examination. The practitioner application process varies by compact. For some compacts, the state licensing board submits information on a practitioner’s eligibility and then the practitioner applies via the compact program’s website by uploading paperwork to demonstrate that they have met the eligibility criteria, pays fees, and confirms passage of a jurisprudence exam if required by the state.² For other compacts, the home state licensing board determines eligibility, the practitioner pays an administrative fee, and the home state issues the compact license. Typically, states charge more for a compact license than a single state license. All health care compacts require an FBI criminal background check. One compact requires practitioners to obtain a single-state license for each state where they wish to practice, but the process of obtaining a license for an additional state is streamlined through a centralized database application.

A compact enacted in state legislation does not automatically require a practitioner in the state to apply for a compact license nor does it qualify a practitioner to practice in multiple states; however, it provides practitioners the option to obtain interstate professional reciprocity, if desired. As of December 31, 2024, there were 17 health care compacts in the United States. (See Exhibit 1.)

Exhibit 1
There Are 17 Health Care Compacts for a Variety of Professions in the United States



Source: National Center for Interstate Compacts.

In general, health care compacts are created to improve access to care and reduce barriers to licensure. While health care compacts do not increase the overall number of practitioners in the national workforce, compacts can redistribute practitioners across states to where they are most needed, potentially increasing access to care in some places. For example, assuming two contiguous states are compact member states, practitioners who participate in compacts (i.e., compact

² A jurisprudence exam protects the public by measuring an individual’s mastery of the knowledge and skills regulated by state law.

practitioners) from a populated county close to a state border can cross the border and provide services to a rural county in the neighboring state that has a provider shortage.

In addition, compacts address barriers to licensure in several ways. Compacts can reduce the amount of paperwork required for licensure in multiple states. Practitioners who apply for multiple single-state licenses must submit duplicative and sometimes different paperwork for each state license. In contrast, compact practitioners can submit a single application to practice in more than one state, making it easier to apply for licensure in multiple states, which may encourage practitioner mobility. Rather than having to adhere to varying state licensure requirements, compact practitioners must instead meet uniform educational and continuing education requirements as specified in the compact's model legislation.³ Once the home state determines that the practitioner meets the uniform compact requirements, they will be able to practice in other member states without meeting additional requirements.

Public health and safety can be monitored by member states that share licensure and disciplinary information in a coordinated database containing information on compact practitioners, allowing each state to access practitioner disciplinary information. Member states must provide investigatory and disciplinary information on compact practitioners to the data system after an adverse action is recognized. 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. Some compacts allow states to use shared disciplinary information to discipline practitioners who commit an adverse action in their home state and to participate in joint disciplinary investigations when a licensee has committed an adverse action in multiple states.⁴

Compacts are developed at the national level with state input; there are two compact models

National stakeholder groups develop health care compacts, states enact model legislation to join compacts, and national commissions administer compacts. According to the Council of State Governments, while compact development processes may vary across compacts, there are common steps.

- State officials and other stakeholders form an advisory body—typically about 20 individuals representing different groups and states—to make recommendations about the structure of the compact.
- A drafting team—composed of five to eight compact and issue experts—takes the advisory body's recommendations and develops a draft compact that is circulated to state officials, stakeholders, and the public for feedback. For example, a group of state medical board executives, administrators, and attorneys assisted by the Federation of State Medical Boards developed model legislation for the Interstate Medical Licensure Compact, the National Council for State Boards of Nursing created model legislation for the Nurse Licensure Compact, and the Department of Defense provided funding to the Council of State Governments to assist in the development of the Social Work Compact to help licensed social workers who are military spouses. Following a comment period, the drafting team revises the draft compact and releases it to the advisory body for final review.

³ Each member state must adopt the compact's model legislation, a legally binding contract between states.

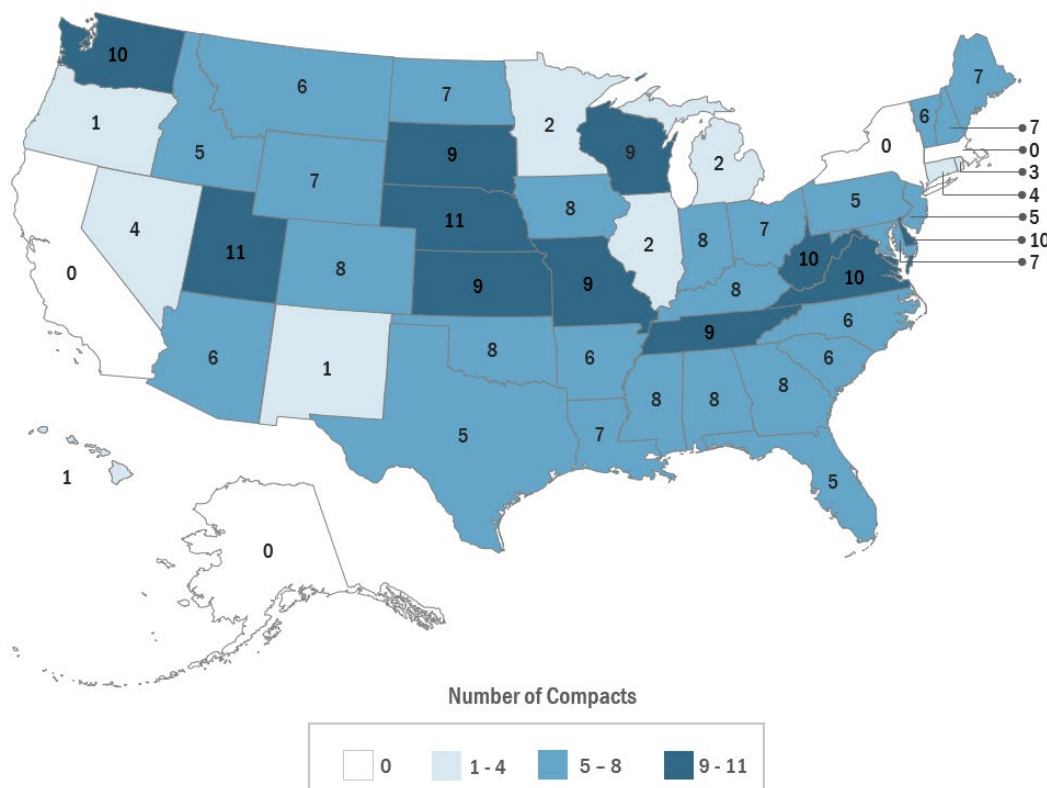
⁴ Generally, adverse action means a disciplinary action taken against a practitioner's license by a licensing board based on a practitioner's misconduct.

- Once the model legislation is finalized, states may adopt it. Once active, compacts generally permit health care practitioners to practice in other states that share the same enacted legislation (i.e., member states).⁵

Every state except Alaska, California, Massachusetts, and New York are members of at least one health care compact. (See Exhibit 2.)

Exhibit 2

All But Four States Are Members of at Least One Health Care Compact



Source: OPPAGA analysis of data from Bogulski, Cari A., et al. "Trends in U.S. State and Territory Participation in Interstate Healthcare Licensure Compacts (2015-2024)." *Journal of Medical Regulation* 111.1 (2025): 8-25. <https://doi.org/10.30770/2572-1852-111.1.8>

Compact commissions are the governing bodies that form after the compact is enacted, usually after a pre-set number of states join the compact. The number of required states needed to enact compacts, which is established in the model legislation, varies. For example, the Interstate Medical Licensure Compact became effective when seven states joined, and the Nurse Licensure Compact became effective when 26 states joined. Following enactment by the required number of states, the compact commission notifies states and hires staff to oversee the compact agreement.

Each compact commission is composed of representatives from all member states and promulgates uniform rules to implement and administer the compact. Commissions have a variety of functions, including

- prosecuting legal proceedings or actions in the name of the commission;
- purchasing and maintaining insurance and bonds;
- borrowing, accepting or contracting for services of personnel;

⁵ The authorizing language in each state's compact legislation must be the same for the compact to be enforceable.

- hiring employees;
- electing and appointing commission officers; and
- other functions as may be necessary to achieve compact purposes.

Health care compact commissions can collect an annual assessment from each participating state to fund commission operations and activities.

There are two health care compact models—mutual recognition and expedited licensure. Both models require practitioners to pay a fee to obtain a compact license in their home state. With the ***mutual recognition model*** a practitioner can practice in remote states using their home state license. Under this model, applicants who want a multistate license via a compact apply for a single state compact license where they live and practice, which allows them to practice in other states. Sixteen of 17 compacts use the mutual recognition model. The model has two sub-models.

- ***Remote state authorization required.*** When the practitioner applies in their home state for a compact license through the compact database, they select the remote state(s) where they want to practice. If the remote state charges a fee, the practitioner pays it, and then the remote state grants authorization to practice in the remote state via a compact license.⁶
- ***Remote state authorization not required.*** When the practitioner is granted a compact license in their home state, they may practice in any remote state without receiving authorization from the remote state.⁷ Practitioners may practice in remote states without paying licensure fees to each remote state.

The ***expedited licensure model*** requires applicants to obtain a license from each state where they intend to practice, but the compact makes the application process more efficient through data centralization and uniform application requirements. The application process begins when applicants provide their credentials to a central entity for storage and transfer. Officials from the home state then determine whether the applicant qualifies for expedited licensure by ensuring that the practitioner meets the educational, licensure, experience, and criminal background check requirements in their state. If qualified, other member states then grant applicants an expedited license to practice. The Interstate Medical Licensure Compact is the only health care compact that uses the expedited licensure model.

QUESTIONS AND ANSWERS

How does Florida reduce barriers for out-of-state practitioners to become licensed to practice in the state?

Florida reduces barriers for out-of-state practitioners by offering multiple avenues for practice. For example, out-of-state practitioners can practice in Florida through licensure by endorsement, telehealth registration, or for some health care professions, interstate licensure compacts. Each of

⁶ Professions in compacts that follow this sub-model are audiology and speech-language pathologists, counselors, dentists and dental hygienists, dietitians, occupational therapists, physical therapists, physician assistants, respiratory therapists, and school psychologists.

⁷ Professions in compacts that follow this sub-model are advanced practice registered nurses, EMS personnel, nurses, psychologists, and social workers.

these pathways has specific application requirements and requires practitioners to practice within the scope of their license.

Health care practitioners from other states can use licensure by endorsement, telehealth registration, or licensure by compact to practice in Florida

Florida provides three options for practitioners from other states who wish to provide health care in the state. This includes licensure by endorsement, telehealth registration, and licensure by compact. **Licensure by endorsement** is an expedited licensure process that allows a health care professional to become licensed in Florida via telehealth or in-person practice based on holding a substantially equivalent or similar health care professional license from another state. **Telehealth registration** allows health care professionals who are not located in Florida to provide health care services in the state via telehealth; telehealth registration prohibits a health care practitioner from opening an office or providing in-person services in Florida. **Licensure by compact** is intended to offer a faster pathway to providing health care across state lines, via telehealth and in-person care. (See Exhibit 3.)

Exhibit 3
Florida Offers Three Options for Licensed Out-of-State Health Care Practitioners to Provide Services in the State

Licensure Component	Licensure by Endorsement ¹	Telehealth Registration	Licensure by Compact ²
Practitioner Eligibility	Any out-of-state practitioner	Any out-of-state practitioner	Compact member state practitioners
License to Practice	Yes	No	Yes
State of Licensure	Florida	Other state	Other state ³
State of Practice	Florida	Florida	Compact member state(s) or chosen expedited member states
Type of Practice	In-person or telehealth	Telehealth	In-person or telehealth
Fee	Varies by profession	None	Compact dependent ⁴

¹ Licensure by endorsement is granted through s. 456.0145, F.S., Mobile Opportunity by Interstate Licensure Endorsement Act.

² Not all health care professions have an interstate licensure compact.

³ With the exception of the Interstate Medical Licensure Compact, for which the state of licensure would be Florida.

⁴ While home states may charge practitioners an initial fee to obtain a compact license, remote states can also charge a fee.

Source: OPPAGA analysis of Ch. 456, F.S.

Licensure by endorsement allows practitioners from other states to become licensed in Florida and includes both in-person and telehealth practice; telehealth registration allows for telehealth practice in Florida only. Licensure by endorsement is an alternative to licensure by examination and allows a health care practitioner to become licensed in Florida based on holding a license in another state that has near-equivalent licensure requirements. In 2024, the Legislature passed Ch. 2024-274, *Laws of Florida*, which created s. 456.0145, *Florida Statutes*, to establish a new universal process for licensure by endorsement for health care professions regulated by the Florida Department of Health (DOH). Seventeen health care professions, including osteopathic physicians, were ineligible for licensure by endorsement prior to the new law.^{8,9} Section 456.0145, *Florida Statutes*, authorizes all health care practitioners who hold an active, unencumbered license issued by another state, the District of Columbia, or a U.S. territory in a profession with a similar scope of practice—determined by the board or DOH—and obtain a passing score on a national licensure

⁸ Anesthesiologist assistants, athletic trainers, chiropractors, clinical laboratory personnel, dental hygienists, dentists, emergency medical technicians/paramedics, genetic counselors, hearing aid specialists, medical physicists, optometrists, opticians, orthotists and prosthetists, osteopathic physicians, physician assistants, podiatrists, and registered pharmacy technicians were previously ineligible for licensure by endorsement.

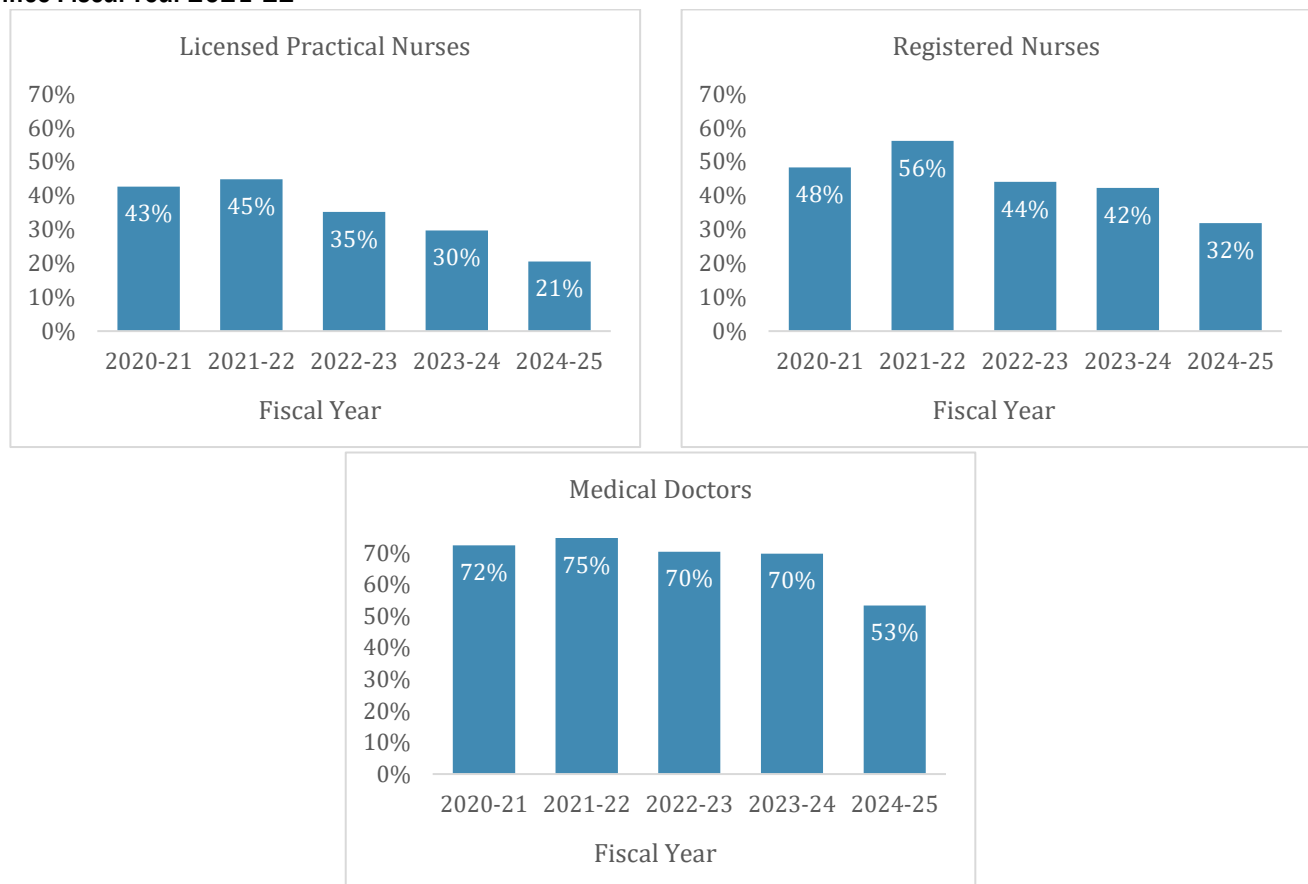
⁹ The Florida Senate, Committee on Fiscal Policy. *CS/SB 1600 Bill Analysis*. February 2024.

examination or hold a national certification recognized by the board (or the department if there is no board) to be eligible for licensure by endorsement.^{10,11} For example, under licensure by endorsement, a practitioner licensed in Georgia who has practiced for at least three years could then practice in Florida.

The percentage of licensed practitioners in Florida who obtain licensure by endorsement has generally declined since Fiscal Year 2021-22. Of all licensed practical nurses who became licensed in Fiscal Year 2020-21, 43% were licensed by endorsement. Similarly, 48% of registered nurses and 72% of medical doctors were licensed by endorsement that same year. By Fiscal Year 2024-25, these rates declined to 21%, 32%, and 53%, respectively. (See Exhibit 4.) Additionally, in Fiscal Year 2024-25, 2% of osteopathic physicians were licensed by endorsement.

Exhibit 4

In Florida, the Percentage of Practitioners Licensed by Endorsement in Each Fiscal Year Has Generally Declined Since Fiscal Year 2021-22



Note: This figure shows the percentage of all practitioners newly licensed in each fiscal year that were licensed by endorsement.

Source: OPPAGA analysis of data from the Florida Department of Health.

¹⁰ An unencumbered license means a license that permits a practitioner to perform all duties authorized under a license without restriction. Other requirements include that the out-of-state practitioner must have actively practiced for at least three years during the four-year period immediately preceding the application submission date; must not be, at the time of application submission, the subject of a disciplinary proceeding in a jurisdiction where they hold a license or by the U.S. Department of Defense for reasons related to the practice of the profession for which the applicant is applying; must not have had disciplinary action taken against them in the five years immediately preceding the application submission date; and must meet the financial responsibility requirements of s. 456.048, F.S., or the applicable practice act, if required for the profession for which they are applying.

¹¹ An applicant for a profession that does not require national examination or certification is eligible for licensure if the applicable board, or DOH if there is no board, determines that the jurisdiction where the applicant currently holds an active, unencumbered license meets established minimum educational requirements and, if applicable, examination, work experience, and clinical supervision requirements are substantially similar to the requirements for licensure in that profession in Florida.

Section 456.47(4), *Florida Statutes*, authorizes health care practitioners located and licensed in other states to perform telehealth services for patients in Florida as long as practitioners register with the applicable board or the Department of Health if there is no board.¹² For example, a practitioner licensed in Georgia could register for telehealth practice in Florida and provide telehealth services to patients in Florida at no additional licensing cost. However, if the practitioner moved to Florida, they would need to get a Florida license to perform telehealth or in-person services. Licensure by endorsement also allows telehealth practice. New telehealth registrations have remained relatively stable for most years since Fiscal Year 2020-21, and more physicians (including medical doctors and osteopathic physicians) than nurses register through telehealth. (See Exhibit 5.)

Exhibit 5
More Out-of-State Physicians Than Out-of-State Nurses Have Registered to Provide Telehealth in Florida in Each Fiscal Year Since Fiscal Year 2020-21

Telehealth Profession	Fiscal Year 2020-21	Fiscal Year 2021-22	Fiscal Year 2022-23	Fiscal Year 2023-24	Fiscal Year 2024-25
Licensed Practical Nurse	1	1	3	1	0
Registered Nurse	9	41	16	25	23
Medical Doctor	1,225	2,705	1,282	1,042	1,054
Osteopathic Physician	115	254	172	172	149
Total	1,350	3,001	1,473	1,240	1,226

Note: This table shows the number of out-of-state practitioners newly registered to provide telehealth in Florida in each fiscal year since Fiscal Year 2020-21.

Source: OPPAGA analysis of data from the Florida Department of Health.

Florida’s participation in several health care compacts provides additional licensure pathways for out-of-state practitioners

Of the existing 17 health care compacts, Florida has passed legislation to join 6. These include compacts for audiology and speech-language pathologists; counselors; physicians; nurses; physical therapists; and psychologists. Of these, Florida actively participates in three compacts. (See Exhibit 6.)

Of the six health care compacts that Florida has passed legislation to join, the state is not currently using the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) and the Counseling Compact. The ASLP-IC is active for licensees in Louisiana and West Virginia, but 33 additional states, including Florida, have passed legislation to join the compact. Similarly, the Counseling Compact is active for licensees in Arizona and Minnesota, but 37 additional states, including Florida and the District of Columbia, are completing the necessary steps to begin receiving applications and authorizing practitioners under the compact.¹³ DOH officials reported that the department anticipates that Florida will become active in both the ASLP-IC and the Counseling Compact by March 2026.

In addition, although Florida passed legislation to join the Physical Therapy Compact, the commission did not accept Florida’s membership because the state’s legislation deviated from the model compact language. Specifically, provisions in 2024’s Senate Bill 7016 materially deviate from the model statute, including omission of the definition of party state, fee language, and language giving qualified

¹² Telehealth registration prohibits the practitioner from opening an office in Florida and from providing in-person health care services to patients located in Florida. While there is no fee to apply or to become registered as an out-of-state telehealth provider, qualified practitioners must maintain liability coverage or financial responsibility that includes coverage for telehealth services provided to patients not located in the provider’s home state.

¹³ The necessary steps include adopting rules and establishing fees; implementing federal criminal background checks with FBI authorization; preparing IT systems to provide data in the required format; assigning and training staff for system use and customer support; conducting full testing of data upload and validation processes; and creating an application process.

immunity to the commission and its representatives.¹⁴ Party state is a term that appears in several operative provisions of the model statute, such as adverse action evidence produced by a party state and investigative information being available to party states via the data system. The legislation also omitted the section of the model statute that states, “the licensee shall pay any applicable fees, including any state fee, for compact privilege;” omission of this language prohibits the commission from collecting practitioner fees for the compact license.¹⁵ Moreover, the legislation removed the qualified immunity granted to the commission and its representatives; removal of this language would expose other member states to potential liability. If Florida enacts new legislation to align with the model legislation, the state can reapply for compact membership.

Exhibit 6
Florida Has Passed Legislation to Join Six Compacts but is Currently Active in Only Three Compacts

Compact	Year Florida Passed Model Legislation	Year Florida Is Active in Compact	Compact Accepting Applications?
Nurse Licensure	2016	2018	Yes
Counseling	2022	N/A ¹	Yes
Psychology Interjurisdictional	2023	2023	Yes
Interstate Medical Licensure	2024	2024	Yes
Audiology and Speech-Language Pathology	2024	N/A	Yes ²
Physical Therapy	2024	N/A ³	Yes

¹ Florida is finalizing rulemaking that will allow the state to begin issuing and receiving compact licenses. The Department of Health reports that Florida will become active by March 2026.

² As of October 28, 2025, the Audiology and Speech-Language Pathology Interstate Compact began accepting applications and issuing practice privileges to practitioners in Louisiana and West Virginia.

³ The Physical Therapy Commission deemed Florida ineligible to grant authorization to practitioners to practice under the compact or accept compact practitioners from other member states because the compact language in Florida statutes deviates from compact model legislation language.

Source: OPPAGA analysis of Florida’s health care compact legislation.

Florida has proposed legislation to join three additional compacts for school psychologists, occupational therapists, and social workers and has not considered joining an additional eight compacts. (See Exhibit 7.) States can enact legislation to join compacts that are not yet active.

¹⁴ The Physical Therapy Compact administrator sent a letter of ineligibility to the Governor, President of the Senate, and Speaker of the House of Representatives on May 8, 2024.

¹⁵ Compact privilege is the authorization granted to a practitioner by a state to practice in said state.

Exhibit 7

Of the 11 Health Care Compacts That Florida Has Not Joined, the Legislature Proposed Legislation to Join Three Compacts

Compact	Proposed or Not Considered	Compact Accepting Applications?	Compact Status
Interstate Compact for School Psychologists	2025 House Bill 327 proposed joining	No	Finalized and available for state enactment. Seven states have officially enacted legislation, allowing for the compact to begin operation. In 2025 compact member states will nominate commissioners and meet to draft the bylaws and rules of the compact.
Occupational Therapy Licensure	2025 House Bill 909 proposed joining	No	Enacted in some states but not yet operationalized; the process to apply for and receive compact privileges still in development.
Social Work Licensure	2025 House Bill 27 proposed joining	No	Enacted in at least seven states and reached activation status; however, multistate licenses are not yet being issued.
Advanced Practice Registered Nurse	Not considered	No	Activation threshold of seven states. As of October 2025, four states have enacted legislation, and five states have pending legislation. The compact will come into effect when seven states have fully enacted the model legislation.
Athletic Trainer	Not considered	No	Activation threshold of seven states. As of October 2025, no states have enacted legislation.
Dentist and Dental Hygienist	Not considered	No	Reached activation status for seven states, however, the compact commission is still acquiring a data system and holding additional rulemaking meetings. The estimated time for the process to be completed is 18 to 24 months from April 22, 2024.
Dietician Licensure	Not considered	No	Finalized and enacted into law by at least seven states, meeting the activation threshold. Commission is continuing to operationalize the compact by acquiring a data system; the process is projected to be ongoing throughout 2026.
Emergency Medical Services	Not considered	Yes	As of November 2025, twenty-five states are members of this compact.
Massage Therapist	Not considered	No	Activation threshold of seven states. As of October 2025, five states have enacted the model legislation and three states have legislation pending.
Physician Assistant Licensure	Not considered	No	Currently developing and implementing the data system. Commission is projected to begin granting compact privileges to practice in early 2027.
Respiratory Care	Not considered	No	Activation threshold of seven states. As of October 2025, four states have enacted legislation, and two states have filed legislation.

Source: OPPAGA analysis of health care compact model legislation and compact websites.

Health care compacts that Florida has joined or considered joining share similar governance and oversight mechanisms

Each compact has model legislation standards that permit licensed health care practitioners to practice in other states that share the same legally adopted regulations. A state must adopt such legislation to be recognized as a compact member. The model legislation for the nine health care compacts that Florida has joined or considered joining have substantively similar governance and oversight mechanisms. (See Exhibit 8.)

Exhibit 8

Health Care Compact Governance and Oversight Elements Include Several Common Provisions

Governance and Oversight Mechanism	Compact Model Elements
Compact Oversight	Each member state shall enforce and take all necessary actions to enforce the rules. The commission has power to intervene in certain circumstances such as during an administrative proceeding pertaining to subject matter of the compact that affects the commission's responsibilities.
Compact Commission	Commission comprised of member states with the power and responsibilities of upholding the compact.
Rulemaking	Commission shall promulgate reasonable rules to effectively and efficiently achieve the compact's purpose.
Default Procedures	- If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or commission rules, the commission will provide written notice to the defaulting state and other member states. - Termination of participation shall be imposed only after all means of compliance have been exhausted
Dispute Resolution	The commission shall attempt to resolve disputes that are subject to the compact and that may arise among member states or member boards when requested by a member state.
Coordinated Data System	Data system will include - practitioner identifying information; - licensure data; - significant investigatory information; - adverse actions against a license; - non-confidential information related to alternative program participation; - any denial of application for licensure and reasons for denial; and - other information that may facilitate compact administration.¹
Compact Withdrawal	A member state withdraws from a compact by enacting repealing statute. Withdrawal is effective 6 to 12 months after enacting the repealing statute.

¹ An alternative program is a non-disciplinary monitoring or practice remediation process approved by a licensing authority to address practitioners with an impairment. Impairment is a condition(s) that may impair a practitioner's ability to engage in full and unrestricted practice without an intervention and may include alcohol and drug dependence, mental health impairment, and neurological or physical impairments.

Source: OPPAGA analysis of compact model legislation.

Florida nurses' participation in the Nurse Licensure Compact has increased, while few physicians and psychologists have joined their respective compacts; OPPAGA could not determine whether Florida compact practitioners practice in other states

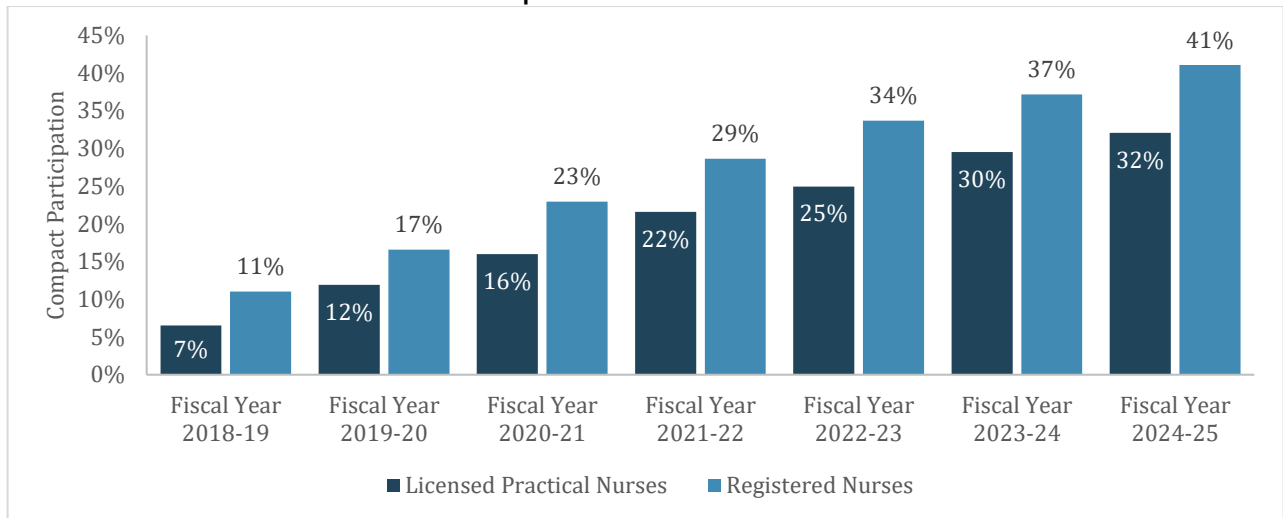
The number of licensed practical nurses and licensed registered nurses in Florida has increased, as has the percentage of nurses who have joined the Nurse Licensure Compact. The Nurse Licensure Compact (NLC) is a multistate agreement establishing a mutual recognition system for licensed practical or vocational nurses and registered nurses. Any nurse who is issued a multistate license from a member state is permitted to practice in any other member state. Florida adopted the NLC in statute in 2016 and became an active member in 2018. To join the compact, nurses apply within

their home state for a multistate license. Once issued a multistate license, nurses must comply with the scope of practice defined by the state where the client is located at the time the service is provided.

The total number of licensed practical nurses (LPNs) and registered nurses (RNs) licensed in Florida has increased by 15% since Fiscal Year 2018-19.¹⁶ In Fiscal Year 2018-19, there were 81,893 LPNs and 353,654 RNs. In Fiscal Year 2024-25, licensed LPNs and RNs increased to 77,745 and 423,104, respectively. The percentage of licensed Florida LPNs and RNs that joined the NLC also increased for both professions during this period. In Fiscal Year 2018-19, the first year Florida became active in the compact, 7% of Florida LPNs and 11% of RNs joined the NLC. By Fiscal Year 2024-25, the percentage of Florida LPNs and RNs that had joined the NLC increased to 32% and 41%, respectively. (See Exhibit 9.) However, OPPAGA could not determine whether these nurses use their license to practice in another state, because the NLC does not require nurses to report this information and DOH does not collect it.

Exhibit 9

Since Fiscal Year 2018-19, the Percentage of Licensed Practical Nurses and Licensed Registered Nurses in Florida That Joined the Nurse Licensure Compact Has Increased



Source: OPPAGA analysis of data from the Florida Department of Health.

Very few Florida medical doctors and osteopathic physicians have been licensed through the Interstate Medical Licensure Compact. The Interstate Medical Licensure Compact (IMLC) is an agreement among states that allows compact states to collaborate to expedite the licensing process for physicians who want to practice in multiple states and U.S. territories. Florida adopted the IMLC into statute in 2024 and became an active member in Fall 2024. To join the IMLC, medical doctors and osteopathic physicians complete one application to become eligible to receive separate licenses from each compact member state where they intend to practice.

In Fiscal Year 2024-25, there were 99,475 medical doctors (MDs) and 14,011 osteopathic physicians (DOs) licensed in Florida. In the same fiscal year, the first year of Florida's participation in the IMLC, approximately 1.2% (1,225) of MDs and 1.3% (187) of DOs licensed in Florida had received licenses to practice in other states via the IMLC.¹⁷

¹⁶ This reflects the number of nurses holding Florida licenses, regardless of whether the nurse is actively practicing in Florida. It does not include out-of-state nurses practicing in Florida through the compact because these nurses are not issued a Florida license.

¹⁷ The total count of licensed physicians includes physicians whose primary state of practice may not be Florida, which may result in an underrepresentation of the extent of participation in the IMLC by Florida licensed physicians. If physicians whose primary state of practice may

In addition to expediting the process for Florida physicians to practice in other states, the IMLC also allows physicians from other states to have a more streamlined process of applying for a license to practice in Florida. The IMLC allows physicians from other states to register their home state licensing board approved expedited license with the compact’s commission, which then allows the practitioner to select to receive a Florida license after paying any applicable fees. In Fiscal Year 2024-25, the first year that Florida became active in the compact, 1,005 MDs and 163 DOs had principal licensure in another IMLC state but had also applied for and received a license to practice in Florida.¹⁸ (See Exhibit 10.) OPPAGA could not determine whether Florida physicians use their IMLC license to practice in another state or whether physicians from other states use their IMLC license to practice in Florida because the IMLC does not require that compact practitioners report such information to state licensing authorities, such as DOH.

Exhibit 10
The Interstate Medical Licensure Compact Has Licensed More Florida Physicians to Practice Outside of Florida Than it Has Licensed Physicians From Other States to Practice in Florida

Physicians Seeking a Compact License	Compact Licensed Medical Doctors	Compact Licensed Osteopathic Physicians
Florida physicians seeking a license in other states	1,225	187
Other state physicians seeking a license in Florida	1,005	163

Source: OPPAGA analysis of data from the Florida Department of Health.

Some Florida psychologists have joined the Psychology Interjurisdictional Compact. The Psychology Interjurisdictional Compact (PSYPACT) authorizes the practice of telepsychology and temporary in-person psychology across compact states.¹⁹ Florida enacted the PSYPACT into statute and became an active member in 2023. To participate in the compact, licensed psychologists apply to the PSYPACT commission for authorization to practice telepsychology in other compact states or authorization to temporarily practice in-person psychology in compact states.

As of June 2025, there were 12,986 psychologists across 43 compact states with the authority to practice interjurisdictional telepsychology and 865 psychologists with temporary authorization to practice in-person psychology. As of September 2025, approximately 15.6% (1,235) of Florida-licensed psychologists could practice telepsychology in other compact states and 0.8% (66) could practice temporary in-person psychology in other compact states. DOH staff was unable to report how many psychologists from outside of Florida are authorized to practice via telepsychology or in-person in the state because there is no requirement for PSYPACT-participating psychologists to report this information to the compact states where they practice.

What are the advantages and disadvantages of joining health care compacts?

Health care compacts have several reported advantages and disadvantages for the state, practitioners, and the public; these advantages and disadvantages vary across compact models. Reported advantages include sharing disciplinary data among states, making multi-state licensure easier, and increasing practitioner supply. Disadvantages include cost and operational challenges and potential conflicts with existing state law. (See Exhibit 11.)

not be Florida are excluded from the total count of licensed physicians, then the percent of MDs and DOs licensed in Florida that have received licenses to practice in other states via the IMLC increases to 1.7% and 1.8%, respectively.

¹⁸ The IMLC defines state of principal licensure as a member state where a physician holds a license to practice medicine and that has been designated as such by the physician for purposes of registration and participation in the compact.

¹⁹ Telepsychology refers to the provision of psychological services using telecommunications technologies.

While some stakeholders reported that health care compacts increase a state's supply of practitioners, OPPAGA found little research evaluating how compacts affect state labor supply or labor mobility, and available research has some limitations. Stakeholders, including the Florida Department of Health and the National Center for Interstate Compacts, reported that data systems to evaluate health care compacts are still being developed and may provide useful information once completed.

Health care compacts have reported advantages and disadvantages for the state, practitioners, and the public; advantages and disadvantages vary across compact models

There are several advantages and disadvantages of health care compacts for the state. Stakeholders reported that health care compacts may facilitate licensure and disciplinary data sharing between states. According to national stakeholders and the Florida Department of Health, the benefit of sharing licensure and disciplinary data is that each state has full knowledge of each compact practitioner's disciplinary history, including information on adverse actions or other restrictions on a practitioner's license that may affect their ability to practice.

In addition, stakeholders reported that compacts are important in certain circumstances, such as during times of crisis, for large hospital systems in the state, and for large state-border populations. For example, stakeholders noted that compacts can efficiently increase the number of practitioners in the state during emergency response following hurricanes and public health emergencies. DOH reported that compacts could benefit multi-state hospital systems in the state, such as Mayo Clinic, that want to bring out-of-state expert practitioners into the state from another hospital. Finally, a stakeholder reported that compacts could benefit states that have large populations on borders with other states, because the compact would allow the state to easily draw on a nearby pool of practitioners.

While all states may benefit from sharing disciplinary data, state authority over disciplinary actions varies by model. In an expedited licensure model, in which each state licenses the practitioner, state boards can take disciplinary action against physicians holding a license in the board's state. In contrast, in a mutual recognition model, only the home state has exclusive power to impose discipline on a compact practitioner; if another state wants to take disciplinary action against a compact practitioner, it reports to the licensure information system and the licensee's home state handles the disciplinary action as if the disciplinary issue occurred in the home state. A remote state can take disciplinary action against a practitioner's authorization to practice only within that remote state, which does not affect the practitioner's multistate license authorizations granted by other member states. This process may take more time to provide discipline since cooperation between two states is needed and the remote state does not have control over the disciplinary action that the home state takes.

In addition, some stakeholders reported that health care compacts may present cost and operational challenges. For example, each health care compact commission can collect an annual assessment from each participating state to fund operational costs and commission activities. Stakeholders, including DOH, also reported that states must invest resources to conform with compact requirements—such as implementing and maintaining the required data system—which may require developing technological infrastructure and providing staff resources. Moreover, a disadvantage for the state with some mutual recognition model compacts (i.e., those that allow a practitioner to practice in any compact member state by gaining recognition through a compact approved home state license) is revenue loss when the state no longer collects licensure fees from out-of-state practitioners.

Compacts may also allow practitioners to circumvent a state's scope of practice. Generally, scopes of practice are described in state law, but compact model legislation may also detail a scope of practice that could, if enacted, conflict with existing state law. For example, the Advanced Practice Registered Nurse (APRN) Compact, of which Florida is not a member, has language that conflicts with Florida's practice and prescribing laws by permitting compact APRNs to practice and prescribe noncontrolled substances without physician supervision. Physician supervision of APRNs is a requirement in 32 states, including Florida.²⁰ The American Medical Association noted lack of supervision as a disadvantage of the compact to states, reporting that it could undermine physician-led care and threaten patient care and safety.

Compacts can be advantageous to health care practitioners because of licensure portability, application ease, and for some compacts, streamlined continuing education requirements and lower licensure costs across multiple states. Some stakeholders reported that health care compacts increase licensure portability, which makes practitioners more mobile. For example, DOH reported that licensure portability is an advantage, particularly for military spouses who may move frequently. Health care compacts also enable practitioners to upload one application and supporting documentation to be licensed across multiple states, making the multistate license process easier. Moreover, some compacts include a unified group of continuing education requirements, which means that applicable practitioners do not need to satisfy varied continuing education requirements across multiple states. Several mutual recognition health care compacts that allow a practitioner to practice in any member state using their compact approved home state license—including compacts for emergency management services personnel, psychologists, nurses, and advanced practice registered nurses—do not require licensees to pay a fee to each state where they intend to practice.²¹

In addition, many health care compacts were created, in part, to support spouses of relocating active-duty military personnel. Health care compacts may allow individuals to retain their home state license during military service periods and obtain practice authorization in a new state. Therefore, a compact reduces the burden of applying for a new state-specific license each time military service personnel spouses relocate. Health care compacts may also waive or reduce some fees for active-duty personnel and their spouses.

Several stakeholders also reported that health care compacts can have advantages for the public. Stakeholders reported that patients can benefit from an increased supply of practitioners within a state. The American Medical Association noted that the Interstate Medical Licensure Compact would potentially reduce access to care challenges in rural areas of Florida because of new physicians practicing in Florida through the compact.

In addition, stakeholders reported that compacts encourage continuity of patient care because compacts may allow practitioners to continue serving patients when patients move out of state. For example, a stakeholder reported that the Counseling Compact, of which Florida is a member, would allow licensed counselors in Florida to continue to provide counseling services to patients who move to another compact member state.

²⁰ Some states may require a physician relationship for a short-term transition period or as a requirement for nurse practitioners to prescribe or practice in general.

²¹ A medical association reported that a potential disadvantage for practitioners is that physicians are required to pay a fee to the IMLC, as well as each state where they are seeking additional licensure, potentially making the overall process costly.

Exhibit 11
Compacts Have General Advantages and Disadvantages and Those That Vary According to the Compact Model



Source: OPPAGA analysis of information from stakeholders and compact model literature.

OPPAGA did not find reliable evidence to support claims that health care compacts reduce workforce shortages and increase access to providers; national stakeholders reported ongoing efforts to evaluate compact impact

Existing research evaluating the effect of compacts on a state's health care practitioner labor supply or mobility has methodological concerns. Available literature is limited to research related to two compacts—nurse licensure and interstate medical licensure—and is hampered by data or methodological limitations. For example, one study found that Nurse Licensure Compact member states had slightly greater use of telemedicine from out-of-state nurses, but the differences were small and not statistically significant. Further, this study included out-of-state telemedicine use by all practitioners rather than only telemedicine provided by nurses, therefore limiting the ability to draw specific conclusions about the impact of the NLC on nurses' use of telemedicine.²² Two additional

²² Norris et al. "The Nurse Licensure Compact's Effect on Telemedicine Usage." *Journal of Patient Experience* 10, (2023): 1-4. <https://doi.org/10.1177/23743735231179060>.

studies suggest that the NLC is associated with the relocation of nurses across states.^{23,24} Specifically, the research suggests that states that join the NLC may experience an increase in the share of nurses who move to other compact states instead of moving to non-compact states. However, both studies have data limitations. In the first study, only 17% of the population examined were registered nurses or licensed practical nurses—the rest were health care professionals who cannot utilize the NLC. The second study used data from the Centers for Medicare and Medicaid Services, which represents a small and potentially unrepresentative subset of nurses, so the findings may not apply to all nurses.

Similarly, stakeholders referenced one study, which has not been peer reviewed, that considers patient access to care and growth in physician practice subsequent to the Interstate Medical Licensure Compact.²⁵ The study found a 3% increase in the number of new out-of-state physician practices following adoption of the IMLC, with most growth concentrated in IMLC states. The study also found that the IMLC increased the number of states where physicians practiced. However, the study's lack of peer review means that experts in the field have not attested to its quality, accuracy, and methodological soundness.

National stakeholders reported that data systems to evaluate health care compacts are still being developed. While a national stakeholder reported that compacts do not currently require reporting that would identify where practitioners work, limiting the ability to determine compacts' effect on labor supply, some stakeholders reported that evaluative efforts are underway. For example, the National Council of State Boards of Nursing developed a database—Nursys E-Notify—that is shared across states; the database has two main components.

- **E-Notify for institutions** acts as a nurse licensure notification system, enabling institutions (e.g., hospital or other health care facilities) to receive real-time notifications about employed nurses. The system provides licensure and publicly available discipline data directly to institutions as such information is entered into the database by participating boards of nursing.
- **E-Notify for nurses** helps nurses easily manage their licenses at no cost. Once enrolled, nurses get automatic notifications about license status, license expiration, license renewal, and publicly available disciplinary actions.

Department of Health officials reported that E-Notify for nurses could allow DOH to determine the number of compact nurses working in Florida, if nurses were required to use E-Notify. For example, a nurse from Alabama who uses the NLC to practice in Florida to assist during an emergency response could use their E-Notify for nurses account to report that they are currently practicing in Florida. However, Nursys E-Notify is a voluntary system, so it may not contain reliable and comprehensive information about where nurses practice. To improve reporting, a state may require that nurses licensed in that state participate in Nursys E-Notify for nurses.²⁶

The National Center for Interstate Compacts also reported that data systems for several compacts—including counseling, speech pathology and audiology, and occupational therapy—are still being developed and are anticipated to be completed in Fiscal Year 2025-26. Once developed, the national center reports that the data systems will allow for more insight into where compact practitioners are

²³ Ghani, Aimi Abdul. "The Impact of the Nurse Licensing Compact on Inter-State Job Mobility in the United States." In OECD Economic Survey of the United States: Key Research Findings, 103-119. Paris: OECD Publishing, 2019. <https://doi.org/10.1787/9789264310278-en>.

²⁴ Shakya, Shishir, et al. "Nurse Licensure Compact and Mobility." Journal of Labor Research (June 2022):260-274. <https://doi.org/10.1007/s12122-022-09333-2>.

²⁵ Deyo, Darwynn, et al. "Access to Care and Physician-Practice Growth after the Interstate Medical Licensure Compact." Preprint, SSRN (March 2024):1-38. <https://dx.doi.org/10.2139/ssrn.4755497>.

²⁶ Delaware, Missouri, Nebraska, and Washington require that nurses licensed in each state maintain a Nursys E-Notify for nurses account.

working, which could then be used to determine where compact practitioners practice as well as how compact practitioners use their licenses. For example, data systems, as well as surveys of compact practitioners, could be used to determine whether compact practitioners use compact licenses to practice via telehealth or in rural areas.

What are key considerations when contemplating participation in health care compacts?

Florida has not joined 11 of the 17 existing health care compacts, including compacts for advanced practice registered nurses, dentists and dental hygienists, dietitians, emergency medical services (EMS) personnel, physician assistants, and respiratory care practitioners. Most recently, the state has considered legislation to join three compacts—Interstate Compact for School Psychologists, Occupational Therapy Licensure, and Social Work Licensure. If contemplating Florida’s participation in additional health care compacts, the Legislature should focus on key compact provisions, including those related to public safety, quality of care, licensure portability, and administrative efficiencies. In addition, the Legislature should consider financial and operational characteristics necessary for compact implementation and participation.

If contemplating participation in additional health care compacts, the Legislature should focus on provisions related to public safety, quality of care, access and continuity of care, licensure portability, and administrative efficiencies

As Florida contemplates joining additional health care compacts, there are key elements in each compact that policymakers should consider. (See Appendix A for details on key provisions.) The 11 health care compacts that Florida has not joined have provisions that support public safety, quality of care, licensure portability, and administrative efficiencies. For example, the compacts address practitioner scope of practice, state roles related to disciplinary action, decreasing administrative burdens through member state cooperation, and use of data systems to organize licensure information, which could reduce practitioner application burdens and allow for the sharing of interstate disciplinary actions.

However, two health care compacts—advanced practice registered nurse and emergency medical services personnel—have provisions that may conflict with the current scope of practice for APRNs and EMS personnel in Florida, which could affect quality of care standards. For example, Florida law currently requires APRNs to practice under a supervisory agreement with a physician.²⁷ While the APRN compact requires that APRNs practicing in member states comply with the state practice laws of the state where the client is located, the compact also explicitly excludes state laws, rules, and regulations that require supervision or collaboration with a health care professional, except for those laws regarding prescribing controlled substances, from its definition of state practice laws. If Florida joined the APRN compact, the compact could allow APRNs from other states to practice in Florida without supervision, thereby exempting compact APRNs from Florida’s practice requirements under current state law. The EMS personnel compact could also conflict with a state’s scope of practice because, unlike other compacts in which the scope of practice is consistent with the scope of practice in the state where the patient is treated, it allows EMS clinicians to practice in remote states within the scope of practice of their home state.²⁸

²⁷ Section [464.012, F.S.](#)

²⁸ The EMS personnel compact does allow appropriate authorities in member states to modify visiting EMS clinician’s scopes of practice and may require additional education or training or a demonstration of competency.

The Legislature may also need to consider allocating funds and staff to join health care compacts; states should also anticipate the potential loss of licensing revenue

Joining health care compacts may require states to dedicate additional funds and resources to implement compact provisions and operate effectively. Each health care compact commission, regardless of compact model, can collect an annual assessment from each participating state to cover the cost of the operations and activities of the commission and its staff. There are no limits or restrictions on the amount of the assessment specified in each compact's model legislation. For the compacts that Florida has joined, the state has paid \$6,000 annually for Nurse Licensure Compact membership since Fiscal Year 2019-20 and \$6,000 annually for Psychology Compact membership since Fiscal Year 2023-24. Compacts for audiology and speech-language pathologists, counselors, and physicians have not charged Florida for participation.

In addition, states may need to hire additional staff and invest in technology to implement compacts. For example, in 2025, the Legislature considered a bill that would facilitate Florida joining the Social Work Licensure Compact. According to a Florida Department of Health bill analysis, joining the social work compact would increase costs for the state. Specifically, DOH estimated a total cost of \$208,776 (\$117,177 of non-recurring funds and \$91,599 of recurring funds) to fully implement the compact, which includes one full-time equivalent position, information technology resources, travel costs and related expenses for a compact commission delegate, and contracted services.

Licensing revenue is a major source of funds to support health care practitioner regulation. Typically, states charge fees for a license; however, Florida may lose licensing revenue from joining mutual recognition health care compacts that do not have provisions for a remote state to charge a fee for a multistate license. Of the 11 health care compacts that Florida has not joined, compacts for APRNs, nurses, psychologists, social workers, and EMS personnel do not allow remote states to collect fees from licensees.

APPENDIX A

Health Care Compact Provisions

Florida has not joined 11 of 17 existing health care compacts. Compacts are designed with the intent to benefit the state, health care practitioners, and the public. Each of the 11 compacts have elements that could support public safety, facilitate licensure portability, and ease administrative efficiencies. (See Exhibit A-1.)

Exhibit A-1

The 11 Health Care Compacts That Florida Has Not Joined Have Provisions That Support Public Safety, Access and Continuity of Care, Licensure Portability, and Administrative Efficiencies

	Interstate Compact for School Psychologists	Occupational Therapy Licensure Compact	Social Work Licensure Compact	Advanced Practice Registered Nurse Compact	Dentist and Dental Hygienist Compact	Dietician Licensure Compact	Emergency Medical Services Compact	Physician Assistant Licensure Compact	Respiratory Care Interstate Compact	Athletic Trainer Compact	Interstate Massage Therapy Compact
Ensuring Public Safety											
Criminal Background Checks ¹	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Authority to Investigate a Licensee for Adverse Action	Any member state	Home state	Home state	Any member state	Any member state	Home state	Home state	Any member state	Any member state	Any member state	Any member state
Any Member State Can Revoke Practice Authorization	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Disciplinary Authority ²	Home state	Home state	Home state	Home state	Home state	Home state	Home state	Home state	Home state	Home state	Home state
Maintaining Quality of Care											
Educational Requirements	Graduated from accredited program	Licensed in home state	Accredited or candidate by accrediting agency	Accredited graduate-level education	Graduated from accredited program	Applicable education, experience, examination	Licensed under practice model	Graduated from accredited program	Holds a credential and license	Holds a certification or a bachelor's degree	Applicable educational experience, examination

	Interstate Compact for School Psychologists	Occupational Therapy Licensure Compact	Social Work Licensure Compact	Advanced Practice Registered Nurse Compact	Dentist and Dental Hygienist Compact	Dietician Licensure Compact	Emergency Medical Services Compact	Physician Assistant Licensure Compact	Respiratory Care Interstate Compact	Athletic Trainer Compact	Interstate Massage Therapy Compact
Maintaining Quality of Care											
Location Where Scope of Practice Law Is Followed	Member state where services are being provided	Member state where the patient is located at time of care	Member state where the patient is located at time of care	Member state where the patient is located at time of care, except as provided in the compact ³	Member state where services are being provided	Member state where services are being provided	Home state ⁴	Member state where the patient is located at time of care	Member state where services are being provided	Member state where the patient is located at time of care	Member state where services are being provided
Supervision Levels	✖	Occupational therapist assistants in a remote state shall be supervised by an occupational therapist	✖	Collaboration with a health care professional only for prescribing controlled substance	✖	✖	Practice under supervision of a medical director	✖	✖	If required by a remote state's scope of practice	✖
Licensure Portability											
Remote state is allowed to charge a fee for license	✓	✖	✖	✖	✓	✓	✖	✓	✓	✓	✓
Support for Military Members and Spouses	Retain home state during active duty	Retain home state during active duty	Retain home state during active duty	✖	Reduced or no compact authorization fee	Retain home state during active duty	Consideration at minimum requirements and expedite applications	Only need an unrestricted member state license	Reduced or no compact authorization fee; retain home state during active duty	Reduced or no compact authorization fee	Retain home state during active duty

	Interstate Compact for School Psychologists	Occupational Therapy Licensure Compact	Social Work Licensure Compact	Advanced Practice Registered Nurse Compact	Dentist and Dental Hygienist Compact	Dietician Licensure Compact	Emergency Medical Services Compact	Physician Assistant Licensure Compact	Respiratory Care Interstate Compact	Athletic Trainer Compact	Interstate Massage Therapy Compact
Administrative Efficiencies											
Data Sharing Across States ⁵	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Requiring only one application process in home state	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

¹ Criminal background checks require submission of fingerprints or other biometric information.

² Disciplinary authority is when a member state holds the power to hold a practitioner accountable for abiding by their state's laws and take adverse action against practitioners who do not uphold professional standards established within that state. For these compacts, remote states cannot take action against a practitioner's license, although states can revoke authorization to practice in the remote state. Remote states must report the disciplinary action to the home state for the home state to take action against the practitioner's license

³ The APRN compact excludes from its definition of state practice laws any state law that requires supervision or collaboration with a health care professional except for laws, rules, and regulations regarding prescribing controlled substances.

⁴ When providing care in a remote state, the EMS clinician must practice only through an EMS agency that is authorized to operate in the remote state. If the modified scope of practice differs from or exceeds that of the home state, the remote state appropriate authority may require additional education or training; and/or mandate a demonstration of competency; and/or restrict the EMS clinician's scope of practice. An EMS clinician providing patient care in a remote state under the authorization to practice is responsible for adhering to the scope of practice modifications or limitations for that remote state, as may be modified by a remote state appropriate authority.

⁵ Licensure information required to report may include identifying information; licensure data; adverse action against a licensee; alternative program participation; denial of application for licensure and reasons; investigative information; other information that may facilitate compact administration.

Source: OPPAGA analysis of compact model legislation.



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